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INTEGRATION OF INFORMATION FOR HOSPITAL RATE SETTING

VOLUME 14: EXCHANGE OF INFORMATION BETWEEN HOSPITAL RATE SETTING AND CERTIFICATE OF NEED AGENCIES: SELECTED STATE EXPERIENCES

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by

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PREFACE

Various provisions of the National Health Planning and Resources Development Act of 1974 appear to call for more orderly coordination of health planning and certificate of need activitities with hospital rate review programs that may in the future be developed at the state level. The three papers in this volume describe the nature of such connections in New York, Arizona and Connecticut. In the first two of these states, these functions have already been centralized within a single department of state government prior to its designation as the new State Health Planning and Development Agency. In the third state, Connecticut, a high degree of centralization at the state level had also been mandated by previous state law.

Each of the papers describes the particular state agency structure within which rate review, planning and certificate of need responsibilities are carried out, outlines their processes and depicts the formal and informal mechanisms by which information is more or less routinely exchanged among the various actors.

The purpose of this effort is to illustrate some of the various approaches that are possible, and to suggest some of the issues involved. We suggest that the papers be read in conjunction with an earlier report in this series by Drew Altman, Connections between Hospital Rate Setting and Planning in Maryland and Rhode Island.*

As will be seen, no attempt has been made to compare the effectiveness of the approaches the various states have taken to address the problem of regulatory coordination. Besides the obvious differences in the demographic, economic, and geographic characteristics of these states, both the objectives and the specific provisions of their certificate of need and rate review or rate setting laws also vary greatly. Moreover, these laws are administered in environments shaped by widely differing histories, traditions

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* NTIS #HRP-0012197.

and underlying frameworks of state government. All such factors combine to make different types of responses appropriate in each state setting. At the same time, as the reader will discover for himself, certain issues and problems appear to be common to all.

Katharine G. Bauer

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INFORMATION SHARING BETWEEN THE RATE SETTING AND CERTIFICATE OF NEED FUNCTIONS IN NEW YORK STATE

This paper describes how information is exchanged between and within the organizations that share regulatory authority over medical care institutions in New York State. Information sharing between the certificate of need (CON) and rate setting functions receives the most detailed attention, although other sharing relationships are mentioned as well. Although the paper does not attempt to analyze the policy implications of linkages among CON, rate setting, and other regulatory functions, the underlying reasoning is that coordination between these functions will almost always be desirable and that information sharing is an important prerequisite of coordination.[1] Therefore, the paper has been written to aid policymakers to link regulatory functions by describing one state's experiences at information sharing.

Because New York has had certificate of need since 1965 and Medicaid and Blue Cross rate setting since 1969, their information sharing arrangements have benefited from a relatively long period of trial and error and so will be of particular interest to policymakers. It is important to keep in mind, however, that the information linkages employed in New York might function very differently (and with different results) in another state. In addition, the reader should be aware that the New York State Department of Health commenced a major reorganization during the period of this study, partly in response to the requirements of P.L. 93-641, but more importantly, in response to the Governor's drive to cut state spending for medical care. Therefore, one should not assume that the rules, structures and policies reported here in October 1976 will be in effect even a few months hence.

In the years immediately prior to New York's first Medicaid cost crisis in 1969, implementation of New York's public health law, Article 28,

had been geared to upgrading health care facilities throughout the state and promoting the quality and accessibility of health services. Despite the passage of the state's Cost Control Act in 1969, establishing prospective rate setting, these goals continued to influence certificate of need and planning decisions during the early 1970's.

In 1975, with the onset of a new, even more serious general fiscal crisis in the state, in which Medicaid expenditures continued to play a major part, the department's priorities underwent a landmark shift to cost containment. The financial situation triggered cost-conscious reactions in nearly every aspect of the state's health regulatory processes, from an outright freeze on regulated hospital rates to a much stricter scrutiny of applications for new construction and services. In addition, the state's low interest loan program for health facilities construction had to be suspended indefinitely with the disappearance of the market for state bonds (and particularly for the Moral Obligation Bonds used to finance hospital and nursing home construction).

This paper has two main sections. The first describes the organizational structure within which different regulatory units share information, and the principal documentary sources of their data. Then, in the second section, actual information sharing procedures are reported. These procedures are categorized by the regulatory processes during which they occur:

- certificate of need governing changes in existing facilities and services;
- establishment of new facilities and new owners;
- computation of hospital prospective rates;
- determination of fiscal sanctions against underutilized hospital services;
- appeals concerning hospital groupings for rate setting;
- waivers of sanctions for underutilization;
- adjustments in rates to reflect new facilities and services;
- utilization reviews; and
- quality of care review.

ORGANIZATIONAL STRUCTURE AND SOURCES OF DATA

New York State is widely recognized as a leader in the United States in the adoption of mandatory regulatory controls on hospitals. New York has accumulated substantial legal authority and programmatic capability over the last 15-20 years to regulate hospitals in six major areas:

- the establishment of facilities and their ownership arrangements;
- the commitment of funds for new facilities and services;
- the determination of prospective per diem rates for Medicaid, Blue Cross insured, and state-financed patients;
- the physical planning, construction, and staffing of new facilities and services;
- the utilization of facilities and inpatient ancillary services;
- the commitment of institutional resources to quality care.

The state reinforces its regulatory "sticks" in these areas with the "carrots" of the Hill-Burton (now Health Resource Development Allotment) funds it allocates and, prior to 1975, with the construction funds provided by the state's own low interest construction loan program.

The state's ability to share information among these regulatory functions is potentially very great, since administrative responsibility in all six areas is concentrated at the state level in a single organization, the Department of Health, and since policymaking authority is controlled in most cases by a single decisionmaker, the department's top official, the Commissioner of Health.

Organizational Structure

Essentially all the information sharing between regulatory functions that takes place in New York State occurs within the Department of Health itself. Beyond the rather limited participation of the department's own employees stationed in its regional health offices, there is little local or regional involvement in New York State in the regulation of either rate

setting, architectural and staffing decisions, or facility utilization. While local and regional councils and committees do have a voice in determinations of need for new capital investments, their influence on ultimate decisions even in this area tends to be minor. One reason is that, in contrast to the state's highly centralized control over decisionmaking in other regulatory areas, at least prior to the conditional designation of regional Health System's Agencies under P.L. 93-641, regional project review responsibilities were diffuse and often overlapping. In a given region, different bodies may have been given specific responsibilities for reviews under the state's own certificate of need program for Federal Comprehensive Health Planning review, and for the Capital Expenditures Review Program (the so-called "A-95 review"). Furthermore, these regional bodies were quite likely to serve incongruent geographical areas. This fragmentation of project review responsibility at the regional and local levels naturally encouraged an accumulation of authority at the state level.

Centralization of authority was (and continues to be) encouraged further by the terms of the various project-review processes themselves, which in most instances leave final decisionmaking authority in the hands of the Commissioner of Health and grant departmental staff in Albany almost exclusive control over the information used in the reviews and ready access to policymakers at every decision point. The dominance of the state staff may be reduced somewhat by the implementation of the Health Planning and Resources Development Act of 1974, which requires the establishment of regional Health Systems Agencies, mandates their participation in the development of a State Health Plan, and grants them a veto over many types of Federal health care assistance in their regions. Nevertheless, the operation of the state's ratesetting and certificate of need programs will continue essentially unchanged, with the commissioner retaining final decisionmaking authority and the departmental staff its central role. In recognition of this centralization, the discussion to follow concentrates on linkages

within the Albany office of the Department of Health.*

The Department of Health in New York State is organized into no less than 75 separate bureaus and offices, many of which directly regulate institutional health care providers. If one were to attempt a one sentence oversimplification of the department's formal structure, one might say it is organized by task rather than by function. The department's project review and rate setting processes are highly formalized, a quality which allows them to be factored into specific tasks which can then be assigned to independent organizational units manned by personnel who learn to perform them on the job. Using this kind of specialization, bureaus which may share strong functional relationships can be (and often are) located in organizationally remote areas of the department.**

The rate setting function is among the more compactly organized; it was originally transplanted into the Department of Health from the Department of Social Services as the Division of Health Economics when prospective rate setting began in earnest in 1970.*** It has been integrated only gradually into the surrounding organization. Included in this division are the Bureau of Health Care Reimbursement, the line agency which administers the rate setting system; the Bureau of Provider Audit, which oversees the state's uniform financial reporting system; and the Bureau of Economic Analysis, which develops the economic statistics necessary in a formula-based reimbursement system such as New York's. The Bureau of

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* Many participants in regional planning efforts around the state, when asked about local linkages between planning and rate setting, simply replied: "There are none."

** Note, however, that the informal organizational structure may perform very differently. Although a thorough exploration of this informal structure is beyond the present study, informal linkages with respect to information sharing were explored and are described later in the paper.

*** A court order and DHEW directive limited the department to retrospective rate setting from the July 1, 1967 date of the state's original attempt to institute prospective rates until December 31, 1969. The division's name was changed in August 1976 to the Division of Health Care Cost Control.

Health Care Reimbursement also contains the Financial Analysis and Establishment Unit, which examines the financial capability of institutions applying for certificate of need and decides on the financial feasibility of new projects. Apart from the activities of this unit, however, the rate setting division's authority is almost entirely limited to the implementation of the rate setting formulas.

The Bureau of Facility Planning is one of three bureaus which comprise the Division of Health Facility Financing and Development. The division's name (along with the names of the other two bureaus which make it up, the Bureau of Architectural and Engineering Services and the Bureau of Hospital Construction Financing) reflects the pre-fiscal crisis emphasis of the Article 28 program, to promote, subsidize, and plan the construction of new health care facilities. As part of the overall divisional mission, the Bureau of Facility Planning computes the regional bed deficits/surpluses on which the determinations of "need" used in the project review process are based. The Bureau of Architectural and Engineering Services oversees the planning and construction of new facilities, approves initial construction plans, and warns when facility plans seem needlessly extravagant. The Bureau of Hospital Construction Financing develops and monitors mortgage agreements with facilities using state construction loans.

Other units of the Department of Health important in institutional regulation include the bureaus within the Division of Hospital Affairs which monitor the compliance with the Hospital Code of hospitals, nursing homes, and "health related facilities." The records of compliance which these bureaus maintain form the basis for the department's determination of the "character and competence" of facilities, an important consideration in CON and other proceedings. The actual compliance records are maintained, and the on-site inspections coordinated, through representatives assigned to the department's regional offices.

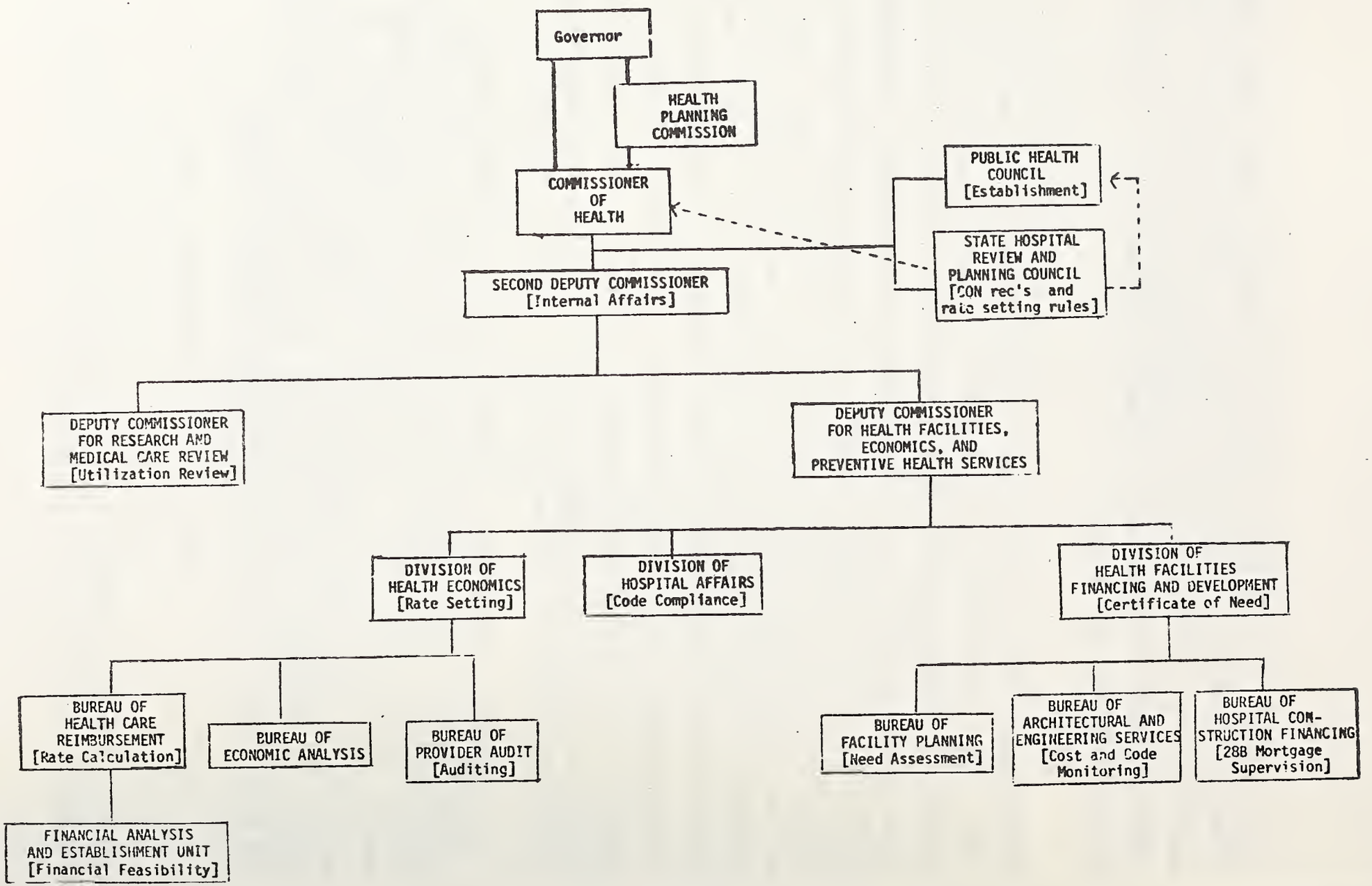
Utilization review is carried out in an entirely different branch of the department, the Research and Medical Care area, led by Deputy Commissioner

Roger Herdman. In New York, however, utilization review is not closely linked with either rate setting or planning. Since this paper is primarily concerned with information sharing between rate setting and certificate of need functions, the department's growing involvement in utilization review will be explored only briefly.

All the divisions and bureaus mentioned above are presided over by Second Deputy Commissioner Frank T. Cicero. Under Dr. Cicero's direction, these organizational units also function as staff to the State Hospital Review and Planning Council and the Public Health Council, the two deliberative bodies involved in CON, rate setting, and regulatory rulemaking. Certain units and individuals within the area also serve the Health Planning Commission, which was recently designated the official State Health Planning and Development Agency (SHPDA) under P.L. 93-641 (the National Health Planning and Resources Development Act of 1974). For example, a new staff group has been established to work with the Health Planning Commission. This staff group will also assist another, more informal panel, the Governor's Health Advisory Committee. The Director of the Health Planning Commission staff, William Leavy, has been associated with administration of the certificate of need program since its first beginnings.

Exhibit A summarizes the organizational structure described above in schematic form. (Only organizational units directly involved in the regulation of medical care institutions and discussed in the present paper are shown.) As mentioned earlier, these organizational arrangements are currently in flux. While Exhibit A will be helpful in understanding the historical information sharing practices reported below, current changes in the department's structure are rendering it rapidly obsolete.

EXHIBIT A: ABBREVIATED ORGANIZATIONAL STRUCTURE OF THE NEW YORK STATE DEPARTMENT OF HEALTH (AS OF JULY 1976) SHOWING MAJOR UNITS INVOLVED IN HEALTH FACILITY REGULATION



Formal Data Sources

The two principal lodes of raw data about hospitals are the Uniform Financial Reports (UFR's) and the Uniform Statistical Reports (USR's). Both reports are maintained by the rate setters in the Division of Health Economics. Since these reports are described in detail in another paper in this series, they will be only briefly described here.[2]

Both reports have evolved over the last 16 years in response to the changing needs of several types of users.

The UFR was developed in conformance with the old AHA chart of accounts, and employs its five-digit coding system. It supplies all the cost and volume data used by the department to calculate the hospital's basic prospective rates before adjustments. The accounts in the UFR separate revenue and costs in patient service centers from other sources of operating revenue and expense, and from non-operating revenue. Monetary data reported on the UFR are carefully audited. However, because the AHA chart was originally designed solely to provide hospitals with internal accounting controls and lacks standardized cost and function definitions, the UFR does not permit reviewers to compare costs between hospitals in any detail.*

The USR is probably the most comprehensive report describing hospitals and their activities currently in use. It was designed to serve many users with a variety of responsibilities. Its 25 pages of schedules include sections devoted to basic descriptive information (board members, physicians, affiliations, etc.); patient characteristics (including both in- and outpatients by age, sex, days, deaths, births, discharges, and source of payment); capital plant and accommodations (including bed complements and construction information); and utilization of services (including utilization of ancillary services by treatment units and by patient age and sex). However, many of the

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* The department is now attempting to develop an improved financial reporting system. A national accounting firm was recently hired to develop the system, and an advisory group established to help them. An attempt will be made to have the new system in place by January 1, 1977.

same types of definitional and reportorial inconsistencies associated with the current UFR also devalue the USR. Here, moreover, there are no systematic audits of the data reported. Recent ad hoc planning reviews, such as the Task Force on Cardiac Catheterization and Surgery in New York City, have uncovered significant inaccuracies.

Additional information from hospitals is usually obtained whenever providers submit certificate of need/establishment applications or make requests for various forms of rate relief.

The department receives no long term capital budget or program plans from hospitals, although recent changes in the Hospital Code require that hospitals maintain three-year plans and make them available upon request during periodic inspections.

Secondary data on regional bed complements are compiled by the Bureau of Facility Planning and updated on a monthly basis. These data, when combined with bed need estimates computed by the bureau, form the basis for the department's planning decisions. In addition, the department has long maintained a State Health Plan. According to the Director of the Bureau of Facility Planning, however, this plan was developed solely for Hill-Burton purposes and never provided the department with a regulatory strategy. The state's main planning concern had been where to locate new or modernized facilities. This objective could be approximated simply by reacting to sponsor applications within the loose framework of the bed need estimates. Since the 1975 fiscal crisis and the widespread concern to eliminate unnecessary beds and services, however, this reactive strategy has been fortified in overbedded regions by an effort to close facilities and services, and the bureau's bed need calculations have had to be supplemented by other information. Since these closure efforts have been undertaken in a crisis setting, and since structural changes in conformance with P.L. 93-641 are in the offing, data collection for these more aggressive policies has yet to be institutionalized in a formal manner.

INFORMATION SHARING

Certificate of Need for Facility and Service Expansions

New York's certificate of need (CON) program is the oldest in the nation. Established in 1965 as a component of a comprehensive regulatory program spelled out in Article 28 of the Laws of New York State, it was designed to be administered in close coordination with the department's programs of code enforcement and licensure, and with the construction funding program referred to above. In the ten years since 1965, 7000 CON applications have been processed for 160,000 health facility beds and 900 ambulatory care projects. *3

The certificate of need process in New York State (as recently revised) includes two separate approval cycles, only the first of which (known as the "Part One" application) involves an explicit planning decision about the need for a given facility or service. This Part One approval requires favorable determinations in the three areas of:

- project need;
- character and competence; and
- financial feasibility.

Local and regional councils usually participate only in the first of these determinations--project need (although their determination of need may take into account local opinion concerning the reputability and solvency of particular providers). Regional councils make recommendations to the State Hospital Review and Planning Council (SHRPC) simultaneously with the recommendations of the Health Department staff; the council then recommends Part One approval or disapproval to the commissioner for his final decision. Although the Part One approval cycle involves numerous participants, the staff's recommendations are usually approved by SHRPC, and SHRPC's

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* Of the 160,000 beds applied for, 90,000 (56 percent) were approved.

recommendations are generally approved by the commissioner.*

The second CON approval cycle (the "Part Two" application) involves detailed investigations of program cost (using informally adopted architectural cost guidelines) and functional program planning, as well as additional investigations of financial arrangements. In contrast to the Part One process, the Part Two application is approved entirely "in-house" within the Department of Health. Final CON approval by the Commissioner requires success in both Part One and Part Two applications. Thus, only one of the six approvals needed for a successful CON application is concerned with the community's need for the facility or service in question. Only rarely in the process are alternatives to proposed projects formally suggested or evaluated.** Both the SHRPC's recommendation and the commissioner's decision are appealable to independent hearing examiners, although appeals are rarely requested due to hearing schedule waiting periods exceeding a year in length.

Information Sharing. Most of the CON information sharing occurs during the Part One application process. It occurs almost entirely within the Department of Health itself, since, by the department's own rules, neither regional planning councils nor applicant institutions are notified of the staff's recommendation to the SHRPC until twenty-four hours before the Council meets.

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* One reason is the lack of time for additional information sharing at SHRPC meetings. The meetings progress so rapidly that colored face pages were recently added to the CON documentation for each application included in the meeting agendas so members could keep their page turning abreast of the Council's votes. The staff has not always dominated the CON process, however. Prior to about 1972, the SHRPC tends to support the recommendations of the regional councils over those of the staff.

** The commissioner does have statutory authority to suggest alternatives, however. On occasion, a staff report will recommend approval contingent on minor changes in a facility's proposal, or recommend disapproval because better alternatives are available. Sometimes, too, the commissioner will send a proposal back down to a regional council for further development. As a general rule, nevertheless, the state's CON process is basically reactive.

The department's influential recommendation to the SHRPC is decided upon jointly by two individuals, the Director of the Bureau of Facility Planning and his supervisor, the Director of the Division of Health Facility Financing and Development. These individuals customarily meet about a month before each SHRPC meeting to review the Part One applications that will be on the agenda and determine the department's official recommendation. They use information sequentially. First, they reject applications for which the planners have determined there is no public need according to their bed requirement estimates. Then, they look to see if any of the surviving applications have been recommended for disapproval by the regional councils. If so, these are examined more closely. However, a negative regional recommendation by no means implies departmental disapproval.

Then, in the third culling process, the recommendations of the Bureau of Architectural and Engineering Services are considered; in most cases, the bureau's recommendations are accepted. The fourth and fifth vetoes are held by the bureaus which assess character/competence and financial feasibility. It is at this point that information from rate setting is used, as will be described more fully in the discussion of the establishment process below. Again, the recommendations of the bureaus usually stand, although the staff members who prepare the written recommendations are sometimes called into the meeting to defend their positions.

The decision process functions less routinely on controversial applications. In these cases, the decision is pushed upwards in the department hierarchy to Dr. Cicero, or on occasion, to the commissioner himself, Dr. Robert P. Whalen. Outside observers claim that the resolution of highly salient decisions is or was often politically influenced, frequently through the Governor himself. There are often no entirely objective or technical solutions to such issues as the closure of hospitals or hospital services, however, and the participation of elective and appointed officials is virtually essential.

Establishment of New Facilities or New Owners

In addition to the CON process for facility and service expansions, Article 28 provides an additional protocol known as the "establishment process," through which licenses and certificates of need are granted to new institutions and licenses modified to reflect changes of ownership. The establishment process parallels the regular CON process in its early stages, during which the recommendations of the state departmental staff and the regional planning councils are prepared and simultaneously submitted to the State Hospital Review and Planning Council. Whereas in the regular CON process SHRPC makes its recommendations to the Commissioner of Health for a final ruling, in the establishment process SHRPC recommends instead to the Public Health Council, which replaces the commissioner as final decision-maker for the issuance and modification of licenses. Even if a new facility is granted a license by the PHC, however, it must still be granted a certificate of need by the commissioner. The PHC's verdicts may be appealed, as may the commissioner's.

Information Sharing. Since the department's role is equivalent in both the CON and establishment processes, the information sharing arrangements are similar. The department's recommendations on establishment applications are arrived at in the same staff meetings in which its CON recommendations are decided. However, the Establishment Subcommittee of the Public Health Council, which screens all establishment applications for the Council, is known to scrutinize the financial competence of applicants with particular care and to look more critically at documentation of need than does the State Hospital Review and Planning Council.*

One rate setting-planning linkage which is particularly important in

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* One source of the subcommittee's reputation is the forceful chairmanship of Morton Hyman, a New York City banker with an understanding of financial problems and an eye for detail. The subcommittee also sees a smaller volume of applications than the SHRPC.

establishment reviews deserves further development. That is the financial feasibility analysis mentioned in the above discussion of CON information sharing as one of the six "vetoes". Although formally incorporated into the facility planning process, these financial analyses are conducted by rate setters in the Financial Analysis and Establishment Unit in the Bureau of Health Care Reimbursement.

In theory, the unit makes three determinations: whether the applicant can secure adequate capital to finance and adequate revenues to operate and pay for the proposed facility or service; whether the facility will produce services efficiently; and whether the new project will have an "unacceptable impact" on per diem rates. With certain exceptions, only the unit's rulings on the first question have had a strong impact on the CON and establishment process.

The Financial Analysis and Establishment Unit was started in response to a number of financial failures among the state's health care providers.* Its work is quite unlike that of other rate setting units, and the data it uses are drawn from the CON applications which pass through the planning division as much as from the Uniform Financial Reports of the rate setters. In a state with budget review rather than formula rate setting, the unit might fit more neatly into the rate setting side. In New York, it is more accurate to say that the unit serves as a bridge between planners and rate setters.

The value of this information linkage has proved itself in other ways besides determination of financial feasibility. For example, the unit's discovery of inconsistencies between financial data reported in project review applications and that reported in the Uniform Financial Reports used in rate setting has led to a closer scrutiny of both documents and efforts to devise a more reliable system of health facilities reporting. The unit's experience also led to regulations barring excessive fees in management contracts, to Consumer Price Index adjustments in "net lease

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* In the same way, the Bureau of Achitectural and Engineering Services was beefed up when a number of construction projects developed severe defects, including one new hospital that floated away during an especially heavy flood.

agreement"* and to facility ownership by dummy corporations which purchase their facilities and services from parent corporations (frequently at higher than competitive prices).[4]

Rate Setting

The rate setting process in New York involves five distinct organizational routines, namely, the computation of rates, the determination of fiscal sanctions, the processing of rate appeals of all types, the processing of requests for waivers of sanctions, and the adjustment of hospital base rates to include expanded facilities and services. Since each of these routines activates different information sharing interactions, they will be discussed separately.

1. Computation of Hospital Prospective Rates

In New York, the computation of hospital prospective rates for Medicaid reimbursement is relatively straightforward, since allowable rates are all projected according to a formula. This formula projects the average per diem rates for different groups of facilities of similar characteristics. Prior to 1976, individual hospitals for routine care could increase reimbursable per diem no more than 110 percent of the previous year's average for their group. In 1976, however, rates were frozen; annual increases were discontinued. Also, for the first time, ancillary outpatient services were brought under group ceilings.[5]

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* Whereby independent landlords receive windfall gains during times of inflati because the health facility leasing the land pays all the (reimbursable) costs of ownership subject to inflation, such as taxes and maintenance, yet also pays the landlord an inflation premium even though the landlord bears no inflating costs. The landlord therefore receives an unjustified increase in rental income while at the same time earning both inflated and real increases in the capital value of his or her property.

Information Sharing. There is little, if any, information sharing between rate setters and other regulatory actors in the computation of basic prospective reimbursement rates for existing facilities. Rate computation for new facilities requires the use of capital cost information developed during the planning process, however. (See Section 5 below.)

2. Determination of Fiscal Sanctions Against Underutilized Services.

Fiscal sanctions are penalties imposed on health facilities by reducing their per diem rates. The first fiscal sanctions were begun in 1974 to penalize hospitals experiencing low occupancy in their obstetrics, pediatrics, or medical-surgical services. In a nutshell, these sanctions are computed so that a hospital is reimbursed for the penalized service at the average per diem rate it would have received if it had satisfied occupancy minimums at its current overall expenditure level. This hypothetical rate, when multiplied by the number of patients actually treated by the hospital in the service, produces a lower figure than the actual (reported) cost of providing the service--hence, the sanction. This sanction is interpreted by departmental spokesmen as an incentive rather than a penalty. The purpose of the incentive is to get hospitals to apply to the planning arm of the department for the decertification of beds in the underutilized services.

In 1975, new fiscal sanctions for underutilization in special inpatient services were adopted, covering coronary angiography, radiation therapy, renal dialysis, and open-heart surgery.

Information Sharing. The computation of the fiscal sanctions themselves is straightforward, once the formula is in hand. The information needed is to be found in the Uniform Statistical and Uniform Financial Reports. It is not until sanctions are appealed by facilities that important information sharing begins.

3. Appeals of Hospital Groupings for Rate Setting and Other Rate Determinations

As mentioned above, the prospective rates in New York State are calculated on the basis of average costs experienced by groups of similar hospitals. Since an institution's rate under this system is dependent on the group to which it is assigned, many hospitals have disputed their similarity with the other hospitals in their group through appeals. These appeals have been less frequent recently than they were when rate setting was first imposed in 1969. Their frequency is expected to increase again, however, as hospitals appeal their groupings in response to the imposition of new ancillary care rate ceilings which were mandated in 1975.

Other rate appeals occasionally encountered include appeals of ceiling requirements, appeals based on extreme changes in economic conditions, appeals based on reporting errors, and so forth. (Literally all aspects of a facility's rates are appealable in New York State.)

Information Sharing. In general, all these rate appeals are handled "in-house" by the rate setters, with little information sharing. However, if a second wave of grouping appeals occurs and if these appeals are given careful consideration, a large amount of information sharing will probably occur. The rate makers responsible for devising the grouping formulas will need the detailed institutional knowledge of both the planners and the regional code compliance representatives in order to judge when hospitals' claims of "uniqueness" are valid.

4. Waivers of Sanctions for Underutilization

A more important appeal process from the standpoint of information sharing, however, is the adjudication of requests for the waiver of fiscal sanctions imposed on hospitals experiencing low occupancy percentages. In New York State, most decisions on these waivers are actually made by the planners rather than the rate setters. Planners take advantage of the utilization

sanctions to get leverage on providers. "The possibility of a penalty gets them to come in for planning," as one department staff member expressed it.

Whether or not the waiver is granted, the final result is likely to be similar. Most facilities which do not appeal sanctions avoid them by decertifying unused beds, which automatically increases their computed occupancy ratio. Facilities which do appeal are often informed that a favorable departmental response will be conditioned on their agreement to apply for bed decertification, although these compromises often involve a lesser decertification than would be needed to avoid the sanction mathematically without an appeal. Only a few appeals are granted unconditionally, usually in rural or other hardship areas. Only a few hospitals (principally certain Roman Catholic institutions) have seen fit to absorb the penalties to avoid decertification. The department's main object in imposing these sanctions is to force reductions in certified bed complements.

Information Sharing. Substantial sharing of information often takes place. The waiver review process begins with the preparation of a list of vulnerable institutions by rate setters in the Bureau of Health Care Reimbursement. This list is sent to the Bureau of Facility Planning where it is edited by the planners there. They edit with a light hand, exempting only hospitals which have changed licensed bed capacity since the rate base year (two years prior), hospitals which have submitted an Article 28 application to decertify beds, or hospitals for which the statistics used in the sanction determination are known to be in error. The edited list is then returned to the rate setters, who notify the hospitals on the list of the pending imposition of sanctions.

If the hospital requests a waiver of the sanction, the ball returns to the planners' court. The planner with the responsibility for the region in which the hospital is located will prepare a written recommendation on the request based on his knowledge of the institution and the planning bureau's list of valid justifications for waivers. The directors of both bureaus then meet and review this written recommendation and decide

the request based on his knowledge of the institution. The directors of both bureaus then meet and review this written recommendation and decide whether or not to grant the waiver. The rate setters cannot waive any sanction not approved by the planners, although they may disapprove additional requests. The department's decision is essentially final--rate setting decisions are not appealable in New York, except to the courts.

A diagram of the fiscal sanctions appeals process is shown in Exhibit B.

5. Rate Base Adjustments.

Requests for rate revisions to reflect additions to facilities and services involve a very substantial amount of information exchange. When, for example, a hospital builds a new wing, it will require revenues to repay the principal, interest, and depreciation costs associated with the new construction, as well as any net increases in operating and maintenance expense which also may be incurred.* The department has the authority to grant these adjustments to "rate base," but it must determine the exact amounts of capital and expense cost that deserve to be reimbursed, as well as whether or not (or to what extent) the expansion was justified by need and efficiency in the first place. Naturally, the financial and planning determinations used in the initial CON process to justify the franchisement of all new projects are potentially very useful in deciding the amounts of these rate base revisions. In fact, to ignore the CON findings would be inconsistent and unfair to providers.

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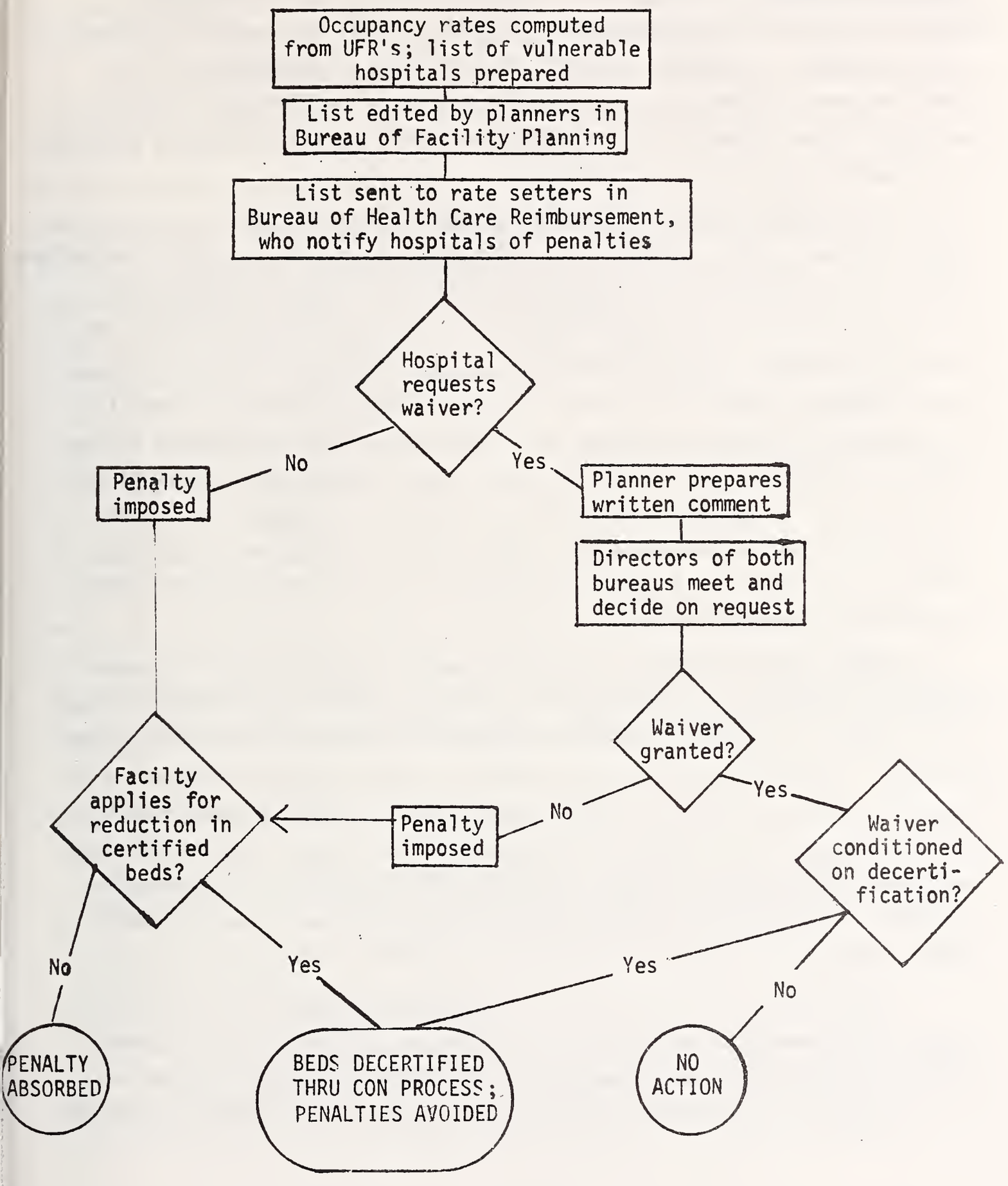
* Only rarely are there net increases in operating expenses associated with capital improvements. Unless new or expanded services are also being provided, the department assumes that these variable expenses will remain the same (if not decrease due to increased operating efficiency in the new structure.)

EXHIBIT B: DEPARTMENTAL ROUTINE FOR WAIVERS OF LOW OCCUPANCY FINANCIAL SANCTIONS



Information Sharing. The mechanism -and the success - of information sharing in rate base modifications differs for capital vs. operating expenses, on the one hand, and between construction and service investments, on the other. According to Mr. Irving Mennen, who directs the Division of Health Facility and Development, "the underlying principle is that all costs approved by the commissioner will be reimbursed."[1]

For capital costs, the planning-to-rate setting linkage is fairly direct, although often complex, as well. Part One CON approval is based on a preliminary capital cost estimate which is amended after more detailed information is acquired and formalized into a Cost Agreement at the conclusion of Part Two. Barring any official changes, the capital cost agreed to at this point (known as the "Approved Cost") will be the absolute maximum ultimately allowed in the rate base. Of course, changes up and down are almost always made in the process of drafting and construction, but unless increases are accounted for by an official modification of the CON (in the case of changes in project scope) or by departmentally approved "change orders" (for less substantial changes), the project will enter the rate base at an amount no greater than the original Approved Cost.

Regardless of the Cost Agreement, however, capital costs are never reimbursed beyond the level of "Certified Costs," even if Certified Costs sum to less than the amount of the "Approved Costs" agreed to in the amended Cost Agreement. Certified Costs are the amounts of funds actually expended during planning and construction which have been validated by a post-construction auditing process. As a general rule, when the rate setters rule on rate base revisions, they adopt the lesser of the two costs, Approved (as amended) or Certified. Providers often argue with the department over these determinations, though, and final calculations are sometimes modified as a result.

Modifications to account for the operating expenses associated with capital improvements proceed with less regularity. Although operating costs are superficially scrutinized as part of the financial feasibility analysis that is part of every Part One CON approval, and although a staffing plan for

new construction and services is approved in Part Two, the granting of a CON does not imply acceptance of these figures by the Department of Health. Instead, regional representatives of the department conduct "management reviews" of new investments as they come on line which result in recommendations as to the magnitude of operating expenses to be added to the rate base. Often, these reviews produce reports that severely undercut the providers' own estimates.

The appeals process for new services is essentially similar to the process for new construction, although accounting for the purchase of a machine or an addition to staff is much simpler than amending and certifying construction costs. This very simplicity causes problems, though, since the length of time required by the department to process rate base appeal applications is so long that a service may be operating for many months before the added costs are incorporated into rates. Although the rates are made retroactive to the commencement of new services (or new construction), cash flow problems may be created. Furthermore, large "hills" are often introduced into the rate structure over time when, for example, an entire year's operating expense of a service is lumped into rates charged during the last three months of the year. If private patients' rates are keyed to Medicaid and Blue Cross rates, patients admitted during the "hill" periods will be overcharged. Individuals in the Department of Health claim that these problems are caused by insufficient advance planning on the part of providers; hospitals disagree.

Other Regulatory Processes

There are other organizational regulatory routines which may create the need or the possibility to share information with the rate setting unit.

1. Utilization Review

While utilization review could have a substantial impact on medical care costs if it were successful in changing the admitting and discharge practices of physicians, in New York the department's utilization review of Medicaid

patients' discharge abstracts has not been linked in any way to rate setting functions. The rate setting program, depending almost entirely on the hospital data in the UFR and USR, makes no use of the length of stay and many other types of patient data in the sophisticated, computerized data system of the utilization reviewers.

However, a potential link exists in the form of retroactive Medicaid reimbursement denials for failure to explain or correct aberrantly long length of stay performances in given diagnostic groups. The Bureau of Medicaid Reimbursement also may deny by its own action the 30¢ per diem added to providers' rates to cover the cost of utilization review data collection if the data gathered proves inaccurate. Neither of these infrequently used powers is truly prospective in character, however, and therefore cannot be considered a rate setting linkage. They are examples of financial control rather than pricing policy.

2. Quality of Care Review

In New York, the regulation of quality by the department has been carried out entirely through the attempted regulation of inputs to medical care processes. The department has avoided explicitly comparing or rating facilities in terms of the care they give. Instead, it has developed a large and detailed hospital code which stipulates architectural standards, standards of professional education for staff, maintenance standards, equipment standards, and so forth.[6] According to participants, the code has been enforced with the department's "carrots" rather than with its "sticks." While few, if any, hospitals have been closed or penalized for code violations, many hospitals have been encouraged to use Hill-Burton and Article 28 grants and loans to bring their institutions up to code. In fact, code compliance surveys were often done in the past to help facilities justify their applications for construction subsidies. With the advent of the financial crisis and the end of construction subsidies, however, the tables have turned somewhat. For example, the compliance status of facilities is now used by planners to help

them decide on potential hospitals to close in their current attempt to reduce overbedding in New York City.

In 1976, the Legislative Assembly, in a new development, required the department to design a quality assessment package for use in ascertaining the quality of care provided by nursing homes in terms of patient needs rather than by the usual process measures. These patient assessments are to be linked to nursing home reimbursement computations. Although a preliminary assessment package has been prepared by a consultant, it is too early to say whether the idea will prove workable.

Another recent development is that in 1976 SHRPC authorized the Division of Health Economics to impose rate setting sanctions on non-code complying facilities equal to 10 percent of their per diem rate. The first such sanctions were approved by the council in August 1976, but there is still disagreement among members over how the sanctions should be handled. They are aimed only at the most incorrigible providers.

CONCLUDING COMMENTS

New York State provides numerous examples of information sharing between units of government responsible for certificate of need determinations and rate setting. The most important and successful linkages are probably the financial feasibility analyses that accompany each certificate of need review and the architectural cost monitoring that accompanies the process of actual planning and construction. To the extent that architectural standards are realistic, the initial CON architectural assessment has proved successful in eliminating unsound construction and in reducing construction costs in many cases. The formal "character and competence" and staffing reviews in the CON process, while less successful, indicate other areas of possible information sharing.

Strong information sharing also occurs during the process of reviewing appeals against the sanctions the rate setting body imposes

against hospitals whose services are underutilized, and during appeals for rate modifications to meet the costs of new hospital construction and/or new services.

On the other hand, because the state has lacked an overall health plan that specified priorities for each of the regions, both planning and rate setting decisions have up to now been almost entirely reactive to the projects proposed by individual hospitals and other providers. Because the formula rate setting program in New York does not require the submissions of either operating or long term capital budgets, it has not obtained information on their future plans to share with planning agencies in order to delineate joint anticipatory strategies.

One other lesson that clearly emerges from the New York experience is the impact on information sharing of a regulatory structure administered in a single agency led by a single decisionmaker. Within the limits imposed by the organization's own structure and policies, information within the bureaucracy can flow quite freely and with a reliable regularity. Informal information sharing can also flourish. There appears to be a danger, however, that an all-powerful state agency will choke the flow of information at regional and local levels even as it promotes exchange among its own bureaus. As the new Health Systems Agencies gain strength this danger may decrease. In New York, the establishment of Health Systems Agencies under P.L. 93-641 has already lessened local Balkanization. In the future, the development of specific state implementation plans required by the law may well give regional bodies a more important say in the state's regulatory policies.

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1. Brown, Jonathan B., A Policy Analysis of Linkages Between Health Planning and Hospital Rate Setting in New York State, Harvard Center for Community Health and Medical Care, Boston, forthcoming.

2. Bauer, Katharine G., Information Available for Hospital Rate Setting in New York State, Harvard Center for Community Health and Medical Care Report, Series R-45-10, Boston, April 1976.

3. Glaude, Arthur J., et al., "Money and Mortar", Hospital Association of New York State, Inc., Albany, New York, 1976.

4. More information on the CON and establishment processes may be obtained by consulting the following New York State Department of Health publications:

   "The Article 28 Story"
   "New York State Department of Health Review and Comment Manual"
   "Manual for Project Review"

   and

   Glaude, Arthur J., et al., op. cit.

5. For a more detailed description of the New York rate setting process, see:

   Bauer, Katharine G. and Arva Rosenfeld Clark, New York: the Formula Approach to Prospective Reimbursement, Harvard Center for Community Health and Medical Care, Boston, Mass., March 1974.

6. Chapter 720, Laws of New York State.

INTERVIEWS

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COORDINATING CERTIFICATE OF NEED AND RATE REVIEW IN ARIZONA

Diane Rowland

COORDINATING CERTIFICATE OF NEED AND RATE REVIEW IN ARIZONA

Arizona provides an example of close structural ties between rate review and certificate of need activities both at the local and state levels. Since 1972, Arizona has had both mandatory review of projected rates of hospitals, nursing homes and health agencies, and certificate of need requirements for all non-Federal hospitals and other institutional health care providers. The basic legislation, enacted in 1971, covers certificate of need, approval of facility construction, review and disclosure of institutional rates and charges, licensure, and uniform accounting and reporting.* The local health planning agencies were given the authority to review and approve proposed construction and expansion of new facilities as well as the responsibility for initial review of proposed rate increases for health facilities. Public hearings for both processes were to be held by the local agency.

This structure results in a high degree of involvement by the local planning agency in reviewing providers' proposals for new or expanded facilities and services and for rate increases. At the state level, planning and rate review activities are centralized in a single agency of state government, the Arizona Department of Health Services. The department has final sign off authority on certificate of need decisions and can override the local agencies' rate recommendations. However, it may only reverse the certificate of need decisions of area planning agencies when it can demonstrate that proper review procedures were not followed, or that the evidence used was not "substantial." In practice, the department rarely exercises its right to supersede local agency rate review recommendations.

Certificate of need and rate review activities are performed for each of the 70 non-Federal hospitals (10,009 licensed beds), 65 nursing homes (4769 licensed beds), and 18 personal care homes (1163 licensed beds).

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* Arizona uses its certificate of need program in lieu of the Federal section 1122 capital expenditures review program.

Certificate of need is required for any new construction in excess of $100,000 and compliance is reinforced by having a certificate of need be prerequisite to construction permit approval, licensure, and reimbursement. Rate review is required before an institution can increase its charges. However, hospital and nursing home compliance with the ensuing recommendations from the rate reviews is completely voluntary. It was hoped that external review of the appropriateness of rates and public disclosure of findings, as well as comparative analysis of charges, would induce facilities to moderate their price increases. While no systematic evaluation has been performed, average rates of hospital charge increase in Arizona have been below the national average, and hospitals rarely set rates counter to the recommendations of the review body.

ORGANIZATIONAL STRUCTURE FOR CERTIFICATE OF NEED AND RATE REVIEW

State Level

The organizational structure of health planning and regulation at the state level is conducive to a coordinated approach. In early 1974, the state's responsibilities for health planning, certificate of need, uniform accounting and reporting and rate review activities were brought together for the first time in the Department of Health Services. This agency has subsequently been designated as the SHPDA for the new health planning law. Planning and regulatory functions are carried out in the Department's Division of Planning and Resources through three bureaus: Health Planning, Health Resources Development and Health Economics.

The Bureau of Health Planning was formerly the statewide 314-A agency. It has been working to accomplish the transitions necessary under P.L. 93-641, producing the Area Designation Plan for Health Services and several accompanying resource documents, including Organizational Alternatives for Health Services, and Geographic Planning for Health Services. Finally, it has drafted the state health plan. Bureau

responsibilities include the development of a health information data base; proposals for facilities, manpower, and health financing and economic policies; and liaison functions with the local planning councils, and with other departmental divisions regarding the development and future implementation of the state health plan.

The Bureau of Health Resources Development is responsible for administering the certificate of need program at the state level, licensure of all health care and day care institutions, architectural and construction reviews and approvals, and certificate of health care providers for Medicare. Its responsibilities in the certificate of need area include issuing all regulations and guidelines governing the local planning agency's certificate of need procedures, acting as the final review agency for determining the need for proposed new or expanded health facilities and by recommending the subsequent permits for CON approved projects. Only one staff member is assigned to conduct analyses of certificate of need proposals, and he has other responsibilities in addition. He must carry the entire burden of organizing reviews of proposals from facilities in areas of the state where planning bodies presently lack staff.

The Bureau of Health Economics has responsibility for the rate review program. It develops the standard forms on which institutions report and has introduced a new uniform accounting and reporting system. A staff health economist conducts special studies, as required, and prepares annual comparative analyses of the costs and charges of Arizona's hospitals and nursing homes for public distribution. The bureau's two full time rate analysts have a number of responsibilities, including:

- review of the rate analyses and recommendations of HSA staff and rate review committees;
- analyses of hospitals and nursing home rate increase applications from facilities located in geographic areas of the state where planning bodies presently lack staff, and from state institutions.

Staff from the bureaus of Health Resources Development and Health Economics

also assist the State Health Planning Advisory Council and its various subcommittees. This council, created by statute and appointed by the governor, is composed of consumers, providers and state and local agency representatives. It serves as the advisory council to the Division of Planning and Resources, and makes recommendations to the Director of the Department. Its Health Economics Subcommittee deals with rate review questions; its Health Facilities Subcommittee deals with certificate of need. At the present time, plans are being completed to replace this committee structure with a new State Health Coordinating Council.

To perform all its planning, regulatory and rate review functions, the Division of Planning and Resources Development has a budget of only $1.2 million out of the DHS total budget of $35 million in state funds; only $136,000 is available for rate reviews.

Local Structure

As of the fall of 1976, Arizona had only one HSA organized, staffed and operating--the Central Arizona Health Systems Agency--located in Phoenix. It embraces the Maricopa County/Phoenix area and two neighboring counties. Roughly half of the non-Federal hospitals in Arizona lie within this HSA, and they have about two thirds of the the total non-Federal beds in the state. Two other HSAs have been designated, one for the southern counties around Tucson, one embracing the Navajo reservation in the northeast, that extends into Utah and New Mexico. Final designation has yet to be made for the remaining counties of the state. HSA designation in Arizona is complicated by the factors of extensive land areas (the state is larger than all the New England states combined), very low population density outside the two major cities, and the fact that 13 native American nations living on 17 reservations comprise a large proportion of this non-urban population and are served in large part by Public Health Service hospitals.

It remains to be seen whether the new HSAs will follow the same

patterns of review that have been developed by the Central Arizona Health Systems Agency. This HSA took over from an unusually strong health planning council that had been organized in the Phoenix area during the era of comprehensive health planning, and which had developed a well articulated process for both certificate of need and rate reviews. With 500 voting members representing 250 organizations and a broad cross section of citizens as well as health care providers, the HSA is organized into several committees and task forces under the direction of an experienced health planner and a board of directors nominated and elected by the members. A staff of nine professionals implement the technical responsibilities of the various committees. Its budget in 1975 was $450,000.

Certificate of need review activities are assigned to subcommittees of a 40 member Project Review Committee. With responsibility to validate community need for new construction and modification as well as the purchase of major new equipment and new services, this committee receives staff assistance from two full time health planners.

Subcommittees of the HSA's 40 member Rate Review Committee conduct individual reviews on all proposed rate increases and make recommendations for modification or approval of rate increase requests. One full time rate analyst assists the subcommittees in their work.

The volunteers who serve on the HSA subcommittees merit special note. The core is drawn from the ranks of management in business in the Phoenix area, where a campaign to control hospital cost increases was sparked by leadership from the Motorola Corporation earlier in the decade. Lawyers, housewives, bankers, hospital accountants and university faculty also serve on the review committees.

INTERACTION AND INFORMATION FLOW BETWEEN CERTIFICATE OF NEED AND RATE REVIEW

The procedures for certificate of need and rate reviews in Arizona encourage a certain amount of horizontal interaction at the state and local levels and vertical interaction between state level actors.

Organizational structures facilitate coordination. As we have seen, at the state level, certificate of need, planning and rate review activities are all within the Division of Health Planning and Resources; formal and informal policy development and discussion can take take place, with the division director providing direction and settling points of conflict. Similarly, in the Central Arizona HSA, the board has final authority over certificate of need and rate review activities and thus can provide direction and policy coordination to the individual working committees. Certificate of need and rate review staff work closely together in making their analyses of individual hospital proposals, under the direction of the council's executive director, and with policy guidance from the board.

In Arizona, the size of the agency staffs, physical proximity, and an informal atmosphere also promote interaction. The Division of Health Planning and Resources is modestly staffed; each of the three bureaus has only five to six professionals in toto. They all work in the same small but modern building. Unfortunately, at the state level, the excessive overload of work on both the DHS certificate of need and rate review staff at the present time serves to hinder the kind of routine communication and consultation on individual proposals that might otherwise be possible.

At the Central Arizona Health Systems Agency, communication between the certificate of need and rate review staff is much freer. They occupy adjacent offices and meet frequently on an informal basis to review the respective applications of individual hospitals and nursing homes. As noted earlier, the HSA volunteer committees that consider the certificate of need applications for a hospital are not the same as those that hear its

rate increase applications, although a number of individuals serve on both.

Communication between the DHS and Central Arizona HSA certificate of need staffs is facilitated by a scheduled weekly meeting to review all pending proposals in the HSA area. This type of interaction would be difficult if not impossible with the HSAs in other parts of the state, however, because of the distances involved. Although the DHS rate analysts do not have scheduled meetings with their staff counterparts in the HSA, they maintain telephone communication and a DHS analyst generally attends the HSA public hearings.

The close proximity of the rate review and planning staff and easy access to files within a single state and local agencies encourages a degree of information sharing that would be difficult if the functions were performed in separate agencies, or within a very large agency. For example, when an expansion project is listed in a rate increase application, the analyst can quickly check the appropriate file to ascertain whether a certificate of need was issued, and what increase in operating costs had been projected in the CON application. Analysts have learned that an institution applying for a rate increase generally paints a bleak financial picture (utilization is down--more dollars needed) to justify its proposed increase, but when applying for a certificate of need the same institution generally paints an optimistic picture (the hospital is overflowing--increased revenues can be expected) to show its need for expansion and its capability to generate revenue. Linking the data in the two applications allows both DHS and the local planning agency to identify the discrepancies and obtain a more realistic picture of the hospital's financial status. It also serves to prevent the hospital from submitting two different sets of data to the different review committees.

In Arizona, one observer noted, "the hospitals have to be a little more honest because they know they'll be closely reviewed by interrelated bodies and thus can't pull the wool over anyone's eyes."

In the certificate of need application one of the eighteen points the applicant must address is the effect of the proposed project on the applicant's rate structure. This information serves as an advance warning that the institution may come in for a rate increase as a result of the proposed project. Similarly, when requesting a rate increase, the applicant is asked to estimate its capital expenditures for the projected year. This estimate of projected capital expenditures alerts the reviewers about a hospital's plans to purchase major equipment or undertake minor facility changes. With advance warning, staff can sometimes effectively discourage poorly planned applications before they get to the stage of formal applications.

The close working relationship between the Central Arizona HSA rate analysts and planners coupled with the small scale of operations alleviates the need for more formal working agreements or policy directives to promote cooperative efforts. The same data base is used by the individuals who staff the two functions. Sharing is informal, as the data are not yet computerized; all analyses of the application packages as well as historical trend analyses are done manually.

The relationships at the state level among the various bureaus of the Division of Health Planning and Resources Development are also informal. The Bureau of Health Resources Development's data on hospital compliance with standards, staffing, licensure, etc., are available to the Bureau of Health Economics staff at any time and are frequently, if not routinely, accessed. Similarly, the Bureau of Health Resources Development can always obtain rate and financial data on the hospitals from the Bureau of Economics. Neither bureau has yet computerized its data, but the Bureau of Health Economics' comparative analyses of the rates and charges of different institutions throughout the state are helpful to staff in both the Bureaus of Health Planning and Health Facilities.

When the Bureau of Health Economics receives an application for a rate increase, claiming need to make outlays in order to comply with state

licensing or staffing requirements, a copy of the application is forwarded to the Bureau of Health Resources Development for review and comment. For example, this bureau may be encouraging a nursing home to increase its staff in order to upgrade its standards to a level to permit Medicare certification. This would be brought to the attention of the Health Economics staff so that a rate increase to support additional staff is not denied. The Bureau of Health Resources Development can also notify the Bureau of Health Economics of pending certificate of need applications that might affect the rate structure. However, there is no routine procedure for such communication. Nor does the Bureau of Health Resources Development request the Bureau of Health Economics to make economic impact analyses of CON applications except in unusual cases. If it were to do so, it is unlikely that the staff would have the time to perform them.

The following two sections describe in detail the various stages of the certificate of need and rate review process.

The Certificate of Need Process

In accord with Arizona law,* a health care institution must obtain a certificate of need from the Department of Health Services (DHS) for capital expenditures which are over one hundred thousand dollars ($100,000)** or in excess of three percent of the institution's operating expenses, for increases in bed capacity, for new medical services, or for substantial modifications in medical services if they will result in increased expenditures or savings of fifty thousand dollars ($50,000) over a twelve month period. The application and review process for certification of need and procedures to be followed are specified in the statute and amplified in regulations issued by DHS.***

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* A.R.S. § 36-433.

** Original legislation set the limit at $15,000, but the ceiling was raised in 1975 amendments to decrease the volume of reviews.

*** R. 9-9-28; R. 9-9-29; R. 9-9-30; R. 9-9-31; and R. 9-9-32.

Applicants planning construction projects file a letter of intent describing the scope, nature, estimated cost, and financial impact of the project with DHS and the local planning agency in their area. The letter of intent must be submitted at least 30 days before the certificate of need application is filed on forms provided by DHS. The letter may set in motion informal communications between the local planning agency and the facility that may result in changes or modifications of the proposal at the preapplication stage.

The certificate of need application, filed concurrently with the local planning agency and DHS, consists of a program narrative and a project resource report. The program narrative provides the justification for the expansion, while the project resource report supplies the reviewer with estimated costs, the method of financing, the effect of total cost on rates and charges, and other staffing and financing information. The specific items are shown in Exhibit A.

HSA Review of Certificate of Need Applications.* When the Central Arizona HSA receives a CON application, a staff member prepares a summary and analysis for the Project Review Committee members. The analyst meets with the chairman of the review subcommittee to discuss the application. Then the subcommittee (three to five members of the overall committee) conducts a site visit and reports its findings. The committee then conducts a formal public hearing and votes on the application. Again, at any stage in this process the facility may be persuaded to modify or withdraw its proposal. The committee's formal action is forwarded to the board of directors or the planning agency for their review and vote. The board can approve or disapprove the application outright, accept the application with stipulations, or send it back to the committee for further evaluation.

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* As previously noted, where there is no local health planning agency, local agency functions are carried out by the DHS staff and the State Health Planning Advisory Committee. When the local planning agency exists but lacks staff, the DHS staff conducts analyses of the CON applications.

EXHIBIT A: APPLICATION FOR A CERTIFICATE OF NEED

The application for a certificate of need shall consist of a program narrative and a project resources report.

1. The program narrative shall include:

   a. A brief summary describing the nature, purpose, and method of construction and any new services or changes in services.

   b. The health problems or needs that will be satisfied by the proposed services or facilities.

   c. The geographic areas and population groups to be served by the proposed services or facilities, including designation of specific site or location of the proposed services or facilities.

   d. Availability of alternative, less costly or more effective means of providing these services or facilities.

   e. A description of any new, expanded or reduced services that will result. This description shall include the following information:

      i. Number of beds applied for, broken down by service or major division of the institution.

      ii. Allocation of beds by nursing units.

      iii. Allocation of beds by patient rooms.

      iv. The number and identification of special service rooms.

      v. Adequacy of existing supporting services such as laboratory, X-ray and laundry if not proposed to be changed by the project.

   f. Contemplated outpatient, social service, home care and preventive medical programs.

   g. Existing and contemplated plans for coordinating services with other institutions and for utilizing supporting service agreements either to obtain or deliver services.

2. The project resource report shall be submitted on forms supplied by the Department and appropriate to the class or subclass of institution proposed, and shall include statements pertaining to each of the following:

   a. Estimated costs or savings, including preliminary estimate of construction costs, if applicable.

   b. Method of financing, including available financial resources with which the applicant proposes to complete the project.

   c. Operating expenses for the first five years of operation by years.

   d. Estimated effect of the total cost or savings of the proposed project on the rates and charges of the applicant.

   e. Operating income for the first five years of operation by years.

   f. Listing of current and/or projected personnel and medical staff.

   g. Listing of each piece of equipment and other property, other than building equipment, which costs in excess of $10,000, and which is being added as a result of the project.

   h. Ability to comply with all applicable Federal, State, and local laws, ordinances, and regulations, including ability to obtain all approvals and consents required from all applicable:

      i. Federal governmental agencies

      ii. State and local governmental agencies.

   j. Qualifications and ability of the applicant to provide and maintain proper:

      i. financing

      ii. staffing

      iii. equipping

      iv. management, and

      v. operation

      of the proposed services and facilities.

   k. Description of the applicant's long-range development plan, if any, and of the relationship of the proposed services or facilities to the same.

   l. Relationship of the services or facilities proposed to the existing health care system of the area in which they are to be located, including relationship with, formal or informal agreements with, and any comments received from, other health care institutions and health care services organizations in the area.

   m. Impact the proposed services or facilities will have on the quality of health care available to the public.

   n. In the case of capital expenditures, a copy of the applicant's latest annual expense budget.

R 9-9-29

The board's final findings and decision on the new application are then transmitted in writing to DHS and to the applicant.

The local agency's findings take into account a wide range of factors, as specified in DHS regulation, R. 9-9-31, reproduced as Exhibit B. The factors to be covered include: assessment of the need for facilities; impact of the project on the availability of care; estimated cost and method of financing; the effect the cost and financing of the project will have on the applicant's future charges; and the conformance of the proposed project to the various state plans including the construction and modernization plan.

The local planning agency conducts its review of the application under a strict time schedule specified in DHS regulations. The entire review process is to be completed within 90 days of the filing of the application. If the application was not complete on submission, the planning agency has 15 days to notify the applicant of the deficiencies. By the 30th day of the process, a public hearing is held at which the applicant may offer oral or written evidence and arguments in support of its project and confront and question those opposed to the project. Both the applicant and DHS are given 14 days notice of the hearing. Within 15 days of the public hearing, the board of directors of the local planning agency must adopt written findings on the proposal and transmit these findings to DHS and the applicant.

DHS Action on Certificate of Need Applications. The director of the Department of Health Services is instructed to adopt the findings of the local planning agency unless the applicant files a written request for review within 30 days of the issuance of findings by the planning agency or the director decides that the findings are arbitrary, capricious, or not supported by substantial evidence. In any of these cases DHS can request further information, hold a second hearing on the application, or return the application to the planning agency for another review. If the application is returned to the planning agency, it must be processed as if it were a new application. The findings issued by the director must state the basis

EXHIBIT B: FINDINGS FOR CERTIFICATE OF NEED APPLICATION

The findings of a local planning agency in regard to certificate of need applications are to include the following factors:

- The relationship of the services or facilities reviewed to the long range development plan, if any, of the applicant.

- The need that the population served, or to be served, has for the services or facilities proposed.

- The availability of alternative, less costly, or more effective methods of providing the services or facilities.

- The relationship of the services or facilities reviewed to the existing health care system or the area in which they are to be provided.

- The availability of resources, including health manpower, management personnel, and funds for capital and operating needs, for the provision of the services or facilities and availability of alternative uses of such resources for provision of other services or facilities.

- The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the areas in which the entities are located or in adjacent areas. Such entities may include medical and other health professions, schools, multidisciplinary clinics, specialty centers, and similar entities.

- The special needs and circumstances of health care services organizations.

- The impact of the proposed services or facilities will have on the quality of health care available to the public.

- The description, nature and purpose, including methods of proposed construction in the case of facilities.

- What health problems or needs will be satisfied by the proposed services or facilities or on what other basis the proposed services or facilities will be needed.

- What geographical areas and population groups will be served by the proposed services or facilities.

- The estimated cost and method of financing or the estimated savings and application of funds and the financial feasibility of the proposed services or facilities.

- What effects the cost and financing will have on the costs, rates and charges of the applicant, or other costs to be borne by the public.

- The ability of the applicant to comply with all applicable Federal, State and local laws, regulations, ordinances, and zoning requirements.

- The ability of the applicant to comply with all applicable professional and institutional standards.

- The qualifications and ability of the applicant to provide and obtain proper financing, staffing, equipping, management and operation of the proposed services or facilities.

- Conformance of the proposed services or facilities with the State Plan for Construction and Modernization of Health Care Institutions.

- Conformance of the proposed services or facilities with any comprehensive health plan or health systems plan that may have been adopted by the agency.

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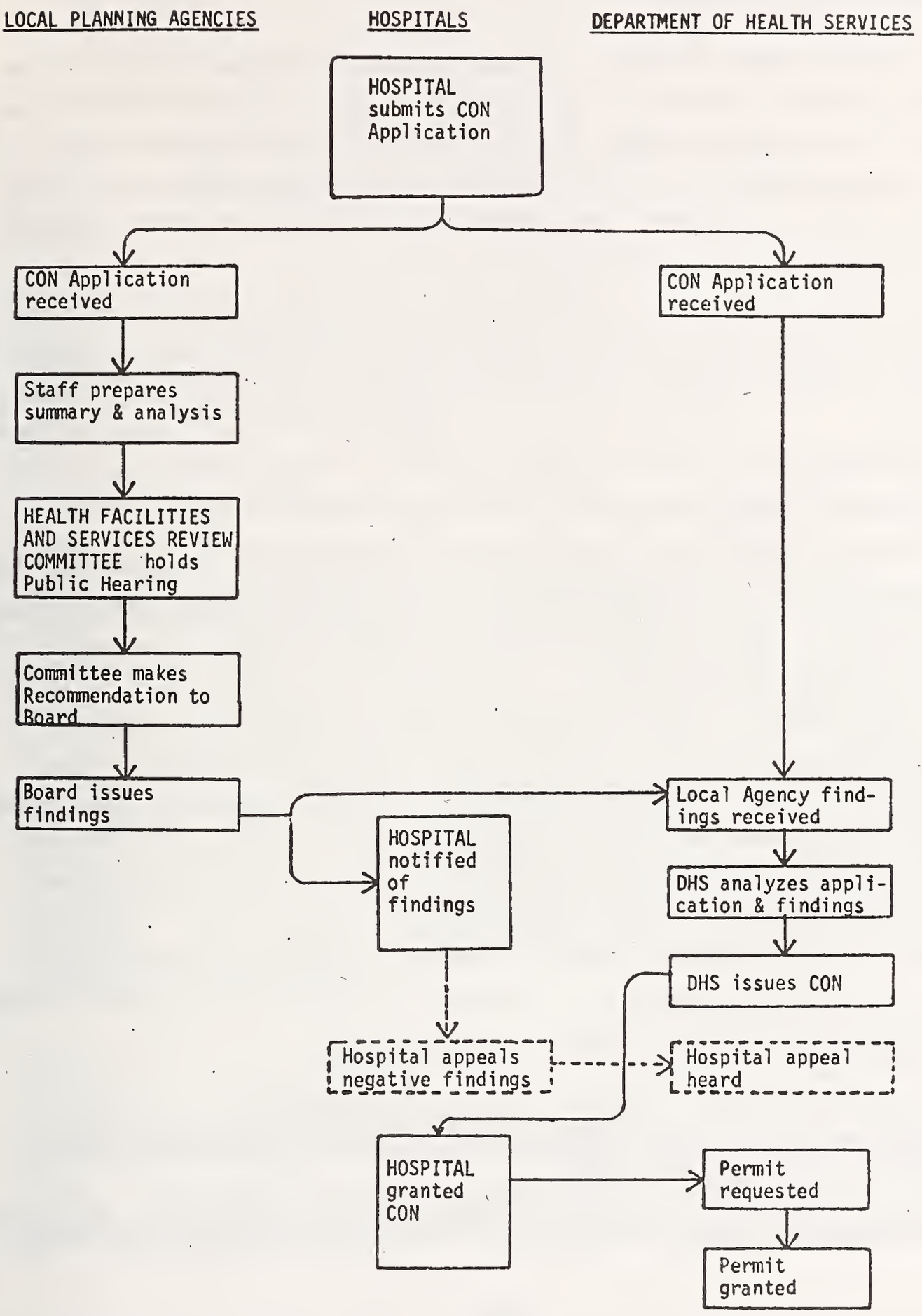
for the decision.

Once the certificate of need has been approved, the permit for construction or modification of the facility can be processed by DHS. This permit request is generally submitted at the same time as the application for certificate of need, but cannot be processed or granted until the certificate of need is awarded. Handled by the Bureau of Health Resources Development, the permit application includes architectural plans and specifications; assurances that the applicant has adequate financial resources to undertake the project and properly staff, equip, and operate it after completion; and assurances that approval for the project has been granted by an authorized planning agency that has found a public need for the project to exist.

In practice, once the architectural plans meet the department's requirements, the permit process seems to be a rubber stamp of the certificate of need. The director of DHS issues the permit for construction. Newly constructed or modified institutions must attach this permit to their application for a license to operate; this license is also granted by DHS.

In sum, then, an institution cannot modify or construct its facilities without a permit for construction and a permit cannot be obtained from the state without a certificate of need approval based on a finding of public need for the project by a local planning agency. Without said permit, the facility cannot obtain a license to operate from the state and must close. A schematic diagram of the complete Arizona certificate of need process is presented in Chart 1 to follow.

CHART 1: THE ARIZONA CERTIFICATE OF NEED PROCESS



The Rate Review Process

Since 1972, all non-federal hospitals, nursing homes, personal care homes, and other health care institutions have been required to submit their planned rate schedule changes to the Bureau of Health Economics of DHS and to the appropriate local planning agency for review and comment as well as for public disclosure. Health facility compliance with the findings of these review agencies is voluntary.*

When the state rate review authorizing legislation took effect in 1972, all health care institutions were required to submit their existing rate or charge schedules, pricing formulas, and related procedures to DHS. Thereafter, all institutions have been required to file any changes in their proposed schedule of rates and charges, or new charges, for review by both the Bureau of Health Economics and the local planning agency.

At the time a proposed increase is planned the health care institution simultaneously files a Financial Report for Review of Proposed Rate Increases for Hospitals (DHS Form 301) with both the state and local review bodies.** These increase requests could be to generate more revenue to meet existing operating expenses or may be to provide additional revenue to support a proposed expansion that has received certificate of need approval. The applicant is asked to summarize its patient revenue, deductions from revenue, other revenue, expenses, and net revenue excess (or deficit) for the prior year, base year, and projected year at existing rates and proposed rates. The applicant is also asked to state the reasons why the rate increase is needed with an indication of which schedules in the filing package support the reasons and conclusions and to provide a statement of its overall pricing policy and financial objectives.

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* See Harold Norris, A Report on the Rate Review Program as Applied to Health Care Institutions - State of Arizona, Arizona Department of Health Services, Phoenix, May 25, 1976.

** For further details, see Diane Rowland, Information Available for Hospital Rate Review in Arizona, working paper R-45-11 of this project (July 1976).

HSA Review. The rate review process begins when DHS and the local planning agency agree that the applicant's filing package is properly completed. The initial stage of review takes place at the local planning agency where the staff prepares a written analysis for the Rate Review Committee, raising questions and offering observations on the nature of the proposed increase. Of the 14 counties in Arizona, only the three counties in the Central Arizona HSA area presently have staff capability for rate review; the staff support for the other areas is provided by the Bureau of Health Economics. The Rate Review Committee or derivative subcommittee must hold a public hearing within thirty days of the filing of the rate increase request. The applicant and the public must be given at least ten days notice of the hearing.

The chairman of the planning agency's rate review committee has considerable discretion as to how the review is conducted. Most often it takes place at the applicant's own facility. The applicant's spokesman presents the justification for the proposed increase and responds to the staff analysis and written questions, which are submitted to all parties several days prior to the site review. The members of the review committee then follow up with additional questions. A staff member of the Bureau of Health Economics is almost always in attendance. The committee's deliberations are conducted in an open meeting room, but the applicant and public are only permitted to comment in response to direct questions from the committee. The committee members frequently ask for information of an advisory nature from the representative of the Bureau of Health Economics. The committee then goes into a public executive session to formulate its recommendations.

Following the public review, the Committee submits its recommendations to the planning agency's board of directors for ratification and transmission to the applicant and DHS. The local agency's findings and recommendations must be issued within 45 days of the applicant's filing date. If the applicant is not satisfied with the local agency's findings, it may submit additional justification to DHS. However, since the

institution does not have to follow either party's rate review recommendations if it continues to be dissatisfied, no formal appeals process is provided.

DHS Review. In the areas of the state where the Bureau of Health Economics staff perform the analyses of rate increase proposals, awaiting full implementation of the state's new HSA network, they try to look at the following aspects of each institution's operation: financial and operating measurement statistics during the prior three years; the relationship of the proposed rates and charges to those of comparable institutions; the methodology used to project future revenues and expenses; the introduction of cost containment approaches or methods to improve productivity; the relation of the institution's expense projections to external economic indicators; the impact of rate increase on the institution's financial stability; the relationship of proposed rates to costs of providing the service; projected capital expenditures and new services including certificate of need status and planned method of financing; utilization trends and plans to overcome underutilization problems, and special areas of cost increase, such as malpractice insurance.

The bureau staff may also perform similar analyses of the rate increase applications being reviewed by the HSA staff. Because of time pressures, however, such in-depth analyses are usually confined to a few applications of special importance. The bureau's economist often provides special types of input into major reviews, such as posing options for methodology by which to predict the hospital inflation factor.

Based on these analyses by the HSA and/or its own staff, the Department of Health Services issues its findings on the proposed increase within 60 days of the applicant's filing date (15 days after the local planning agency must issue its findings and recommendations). The director of the department can either adopt the recommendations of the

local agency or issue a separate set of findings and recommendations. In practice, DHS rarely overturns a local agency decision.

Upon being notified of the state's action, the applicant can elect to follow the recommendations or disregard them, since they are not legally binding. In all but two instances the hospitals have chosen to comply.

A schematic diagram of the complete rate review process in Arizona is presented in Chart 2.

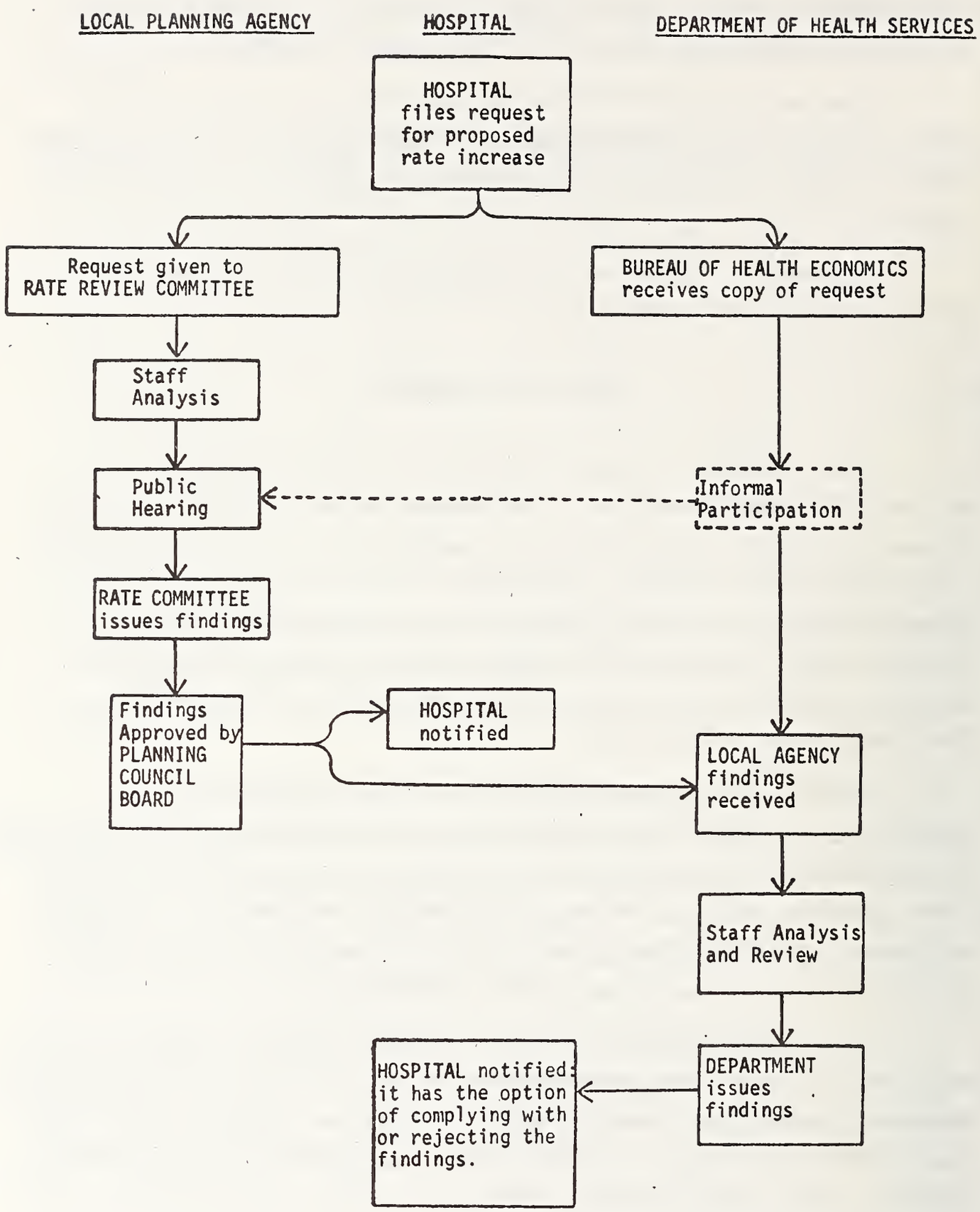
CONCLUDING COMMENTS

The integration of rate review and regulatory functions in Arizona offers many advantages. Good communication is possible not only between rate review and certificate of need analysts, but with licensing and certification reviewers. For example, licensing and construction inspection teams can report quality of care problems to the Health Economics staff, and complaints on costs due to licensing requirements that are raised during the rate review process can be transmitted to the Bureau of Health Resources.

Second, both at the state and HSA levels, analysts have full access to each others' files. Soon, the introduction of uniform accounting and reporting of the information to be entered on the standard package of forms for state and local review will alleviate the problems of noncomparable data (based on differing definitions and non-standard reporting conventions) that occur in many other jurisdictions.

Third, the applicants for certificate of need and rate review need only complete one filing package for use by both the state and local agency. Moreover, the applicant needs to deal with only one agency at each level, thus minimizing the administrative burdens and conflicting jurisdictional problems endemic to many other systems.

CHART 2: RATE REVIEW PROCESS IN ARIZONA



Finally, the tie-in between certificate of need and rate review permits more informed decisionmaking. For example, during review of an applicant's proposal to increase rates to support a new service or capital project, the proposed charges can be checked against the applicant's original CON statement on cost impact. Where the rate review and CON analysts work closely together during the CON proposal stage, as in the Central Arizona Health Systems Agency, they have a check on the institution's statement of the impact of its proposed expansion project on future rates; they can compare the statement with actual rate increases that have been necessary when similar institutions have implemented similar projects. Also, by looking at both the optimistic financial and utilization picture an applicant may present in a certificate of need application and the bleak fiscal picture this same applicant may present in its request for a rate increase, the certificate of need and rate reviewers can formulate questions of fact that help them obtain a more realistic assessment of the institution's actual financial status.

Despite these advantages, however, the Arizona system operates under two types of serious constraints that undoubtedly handicap its effectiveness. First, the rate recommendations of the local and state agencies are not enforceable. This may well result in softer recommendations than might otherwise be made, since neither agency wants to expose itself to the embarrassment of being overridden by institutions who decide to take independent action. However, this risk is somewhat tempered since, in the present cost conscious environmnet, individual institutions have much to gain in the eyes of the community if they comply with the recommendations of the reviewing agencies.

Second, the number of staff analysts available to conduct certificate of need and rate reviews is pitifully small compared to the magnitude of the tasks they are expected to perform, and the potential cost impact of their activities on health care costs in Arizona.

Furthermore, looking ahead to the time when the newly formed HSAs

in Arizona will take over the types of responsibilities now performed by the Central Arizona HSA and the Bureau of Health Economics, there is a serious question as to whether they will have the resources necessary to implement the CON and rate reviews at even the present level of thoroughness. While the advent of uniform accounting and reporting, once the transition has been made, may somewhat simplify the rate review process, it will always demand skillful analysts. Whether the pool of knowledgeable volunteers that the Central Arizona HSA has been able to attract to its various review committees can be reproduced in other areas of the state also remains to be seen. A final question is whether volunteers can be relied on over the long pull to contribute their time and effort to the committee work, especially in areas of the state where they must travel considerable distances to conduct reviews.

REFERENCES

Interviews: [Held January 12th and 13th, 1976]*

Department of Health Services; Divison of Health Planning and Resources: Richard Turkian.

Bureau of Health Economics: Harold G. Norris, Stephen Jenkins, Calvin Lockhart, and Thomas Van Slyck.

Bureau of Health Facilities: Don Nerf.

Bureau of Health Planning: George Sachen.

Bureau of Health Manpower: Dan Wagner.

Central Arizona HSA: Milton Gan, Executive Director

Arnold Sabel, General Manager of Government Electronics of Motorola and head of CAHSA Rate Review Committee.

Documents

Norris, Harold G., A Report on the Rate Review Program as Applied To Health Care Institutions - State of Arizona, Arizona Department of Health Services, Phoenix, May 25th, 1976.

Rowland, Diane, Information Available for Hospital Rate Review in Arizona, Harvard University Center for Community Health and Medical Care, Report Series R-45-11, Boston, July 1976.

* Much of this information was updated by interviews in October 1976 by Katharine G. Bauer. Note that in the interval the Bureau of Health Facilities and the Bureau of Health Manpower have been combined to form the new Bureau of Health Resources.

COORDINATING RATE REVIEW AND REVIEW OF CAPITAL EXPENDITURES: THE CONNECTICUT EXAMPLE

Margaret Sweetland

COORDINATING RATE REVIEW AND REVIEW OF CAPITAL EXPENDITURES: THE CONNECTICUT EXAMPLE

Insurance, it is widely recognized, is big business in Connecticut. But the Nutmeg State has another (related) big industry: health care. An indication of the great size of the health sector in Connecticut is a remark made recently by a health planner employed in state government: "When you talk about hospitals in Connecticut, you're talking about an $800 million business."[1] Three years ago the state's general assembly delegated the responsibilities of monitoring and controlling the development and costs of health services in Connecticut to a small, consumer-dominated agency under the administrative control of the State Department of Health.[2] Called the Commission on Hospitals and Health Care (CHHC), this single agency is empowered to perform the dual functions of project authorization and financial control of all of Connecticut's nongovernmental health facilities.

The commission's powers include review and approval of health facilities' proposals for new services and capital expenditures (certificate of need). In addition, a prospective reimbursement program for the state has been developed whereby the commission must annually review all hospitals' budgets for the coming fiscal year, as well as any proposed rate increases. The commission is required to hold public hearings on health facilities' proposals within statutorily defined time limits. Compliance with both CON and rate review decisions is mandatory.

The Connecticut system of uniting planning (CON) and rate review in a single organization, where decisions are made through public disclosure and debate, has several potential advantages. In theory, duplicative efforts (such as collection of the same data) should be reduced. Communication between planners and rate setters should be facilitated. The public's awareness of the health care system and providers' and institutions' sensitivity to their "community image" should be enhanced.[3] Finally, and most important, the overall quality and coherence of health planning and cost containment decisions should be augmented.

The methods and consistency of the information exchange between planners performing certificate of need determinations and rate setters at the Commission on Hospitals and Health Care are focus for this discussion. It is important to note early on in any report on health regulation in Connecticut, however, that there are other bodies in the state attempting to control hospital costs. Although only the commission performs the certificate of need function, it is not the sole agent in determining Connecticut hospitals' rate schedules. Two other organizations in the state--one governmental (the Committee on State Payments) and the other private, not-for-profit (Conneticut Blue Cross)--carry on rate setting programs of their own: 1) the Committee on State Payments is mandated to determine reimbursement rates for patients and others supported by Federal (Titles V and XIX) and state programs.[4] The committee establishes reimbursement rates for 635 providers in the state including statutorily defined acute care, chronic disease, and long-term care hospitals, psychiatric hospitals, mental retardation and rehabilitation centers, etc.[5] 2) Connecticut Blue Cross has a prospective reimbursement program of its own involving "a target per diem cost for non-maternity care which is developed from a budget negotiated between each hospital and Blue Cross."[6]

The Commission on Hospitals and Health Care has had a more direct relationship with the Committee on State Payments than with Blue Cross. Two members of the commission also serve as members of the Committee on State Payments (see following section). In the past, however, no such direct link between CHHC and Blue Cross has existed. Certain differences in design and scheduling between their two prospective reimbursement programs have given rise to duplicative efforts and disagreements. Modifications are now being considered to correct past discrepancies and improve coordination:

(1) Until this year, Connecticut hospitals have had to prepare and submit two budgets to two review panels, with the result that "the budgets [were] often different because of different submission dates."[7] For review of the FY 1977 budgets, however, Blue Cross and CHHC agreed to utilize the same budget reporting forms and deadlines. This practice is expected to continue in the future.

(2) "Whenever the Commission or Blue Cross approves a higher level of expenditures than the other party deems reasonable, hospital administrators have an added bargaining tool in their negotiation with the other party, be it Blue Cross or the Commission. Equalized third-party payments [would] correct this problem as well as save time. . . ."[8]

It is hoped that progress toward standardization of all payers' rates for hospital care in Connecticut can be made possible by a grant recently awarded to the commission by the Social Security Administration. In September 1976, SSA's Division of Health Insurance Studies approved a $236,000 grant for the commission to develop an effective statewide system of prospective reimbursement.[9] The experimental prospective reimbursement plan proposed by CHHC would attempt to "apportion total financial requirements among various third-party payers of care - federal, state, Blue Cross and commercial insurance carriers - [so that] each of them pay the same rate for hospital care as that paid by members of the public making direct payments."[10]

(3) Until recently, "Blue Cross steadfastly has adhered to a position of attempting to justify the continuation of a discount, which in Connecticut [has been] approximately 3 percent below charges statewide."[11] Lately, however, Blue Cross has indicated to the commission its "willingness to consider" elimination of its favorable discount.[12]

Although the interface between CHHC and Blue Cross has been inadequate, a greater degree of coordination is demonstrated in the commission's internal operations, as well as in its interactions with several other government health agencies in the state. Decisions handed down by the commission represent shared effort by the commissioners and the CHHC staff. The commission has two staff units, the Division of Health Planning and the Division of Health Care Finances. The two divisions perform preliminary documentation and review of health facilities' proposals and budgets, and apprise the commissioners of necessary background information as well as the results of their analyses.

Within the same general framework of health cost containment strategies, the commission's two divisions have different functions. The Division of Health Planning is responsible for reviewing applications submitted by general hospitals and long-term care facilities for capital expenditures or new services, increasing and maintaining a statewide health planning data base, and providing technical assistance for seven health

care task forces.* The function of the Division of Health Care Finances is to monitor and review costs and the rate schedules of Connecticut's nongovernmental health facilities. The finance staff's activities include analyses of budget documents, cost reports, and other statistical data.

The two divisions' tasks are separate, but related. It is necessary, therefore, for planners and rate setters at CHHC to keep each other, as well as the commissioners, abreast of their different activities. Active communication between the two divisions (regarding, for instance, data or problems they encounter) is especially important when each is contemplating a recommendation about the same facility or service area. As decisions evolve within the commission, information must also be obtained from or provided for other bureaus within the state government (e.g., the Facilities Construction Section of the State Health Department). Ongoing exchange and validation of information are necessary to maintain consistency and fairness in the commission's decisions affecting the same facility (or a consortium of institutions), and hence sustain providers' and the public's belief in the commission's credibility.

A recent report by the Council of State Governments included the observation that: "At present the Connecticut CHCC has most of the 'health organization pieces' it needs to perform its duties."[13] The report went on to say that, "While [the commission's] regulatory activities. . .appear extensive, officials indicate that only a fraction of their existing regulatory authority has been implemented."[14] A member of the CHHC staff recently commented that, during the commission's three-year history, greater emphasis has been placed on development of budget review criteria and refinement of financial analysis techniques than on planning.[15] Efforts to correct this disequilibrium between planning and rate setting at CHHC are now underway. This discussion will examine some of the methods now in use at the commission to more closely align the two functions.

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* The purpose of these task forces is to evaluate and make recommendations on specific aspects of the health delivery system in Connecticut, so that fragmentation of care will be reduced and access to services will improve. The task forces have been appointed in these areas: open heart surgery; hemodialysis centers; primary care; long-term care; acute care; ambulatory surgery programs; and C-T scanners.

ORGANIZATIONAL STRUCTURE FOR PLANNING AND RATE SETTING

Background

The State of Connecticut has 36 general short-term hospitals (10,546 staffed beds) serving a population of 3,124,400.*[16] Connecticut exceeds national averages in hospital beds per 10,000 population (68 in 1973, as compared to 45 nationally), and in physicians per 10,000 population (20 in 1973, compared to 16 nationally). Connecticut residents' expenditures for health care substantially outdistance the national average as well: in 1973, average daily hospital costs in Connecticut were $149, or 29.5% higher than the national figure for that year of $115.[17]

During the decade since the Medicare program was enacted in 1965, hospital costs in Connecticut, as in all states, have escalated precipitously. In 1973, Connecticut's General Assembly, desirous of braking the hospital cost spiral, authorized formation of the Commission on Hospitals and Health Care in the interest of "creating a working partnership between the institutional health care provider and state government."[18]

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* The 36 hospitals include one municipal facility (in Meriden) and one short-term children's general hospital (in Newington). Other facilities in the state include: 10 chronic disease hospitals; 211 chronic and convalescent nursing homes; 65 rest homes with nursing supervision; 167 homes for the aged; as well as numerous drug and alcohol rehabilitation facilities, psychiatric and mental retardation centers, home health services, etc. For a complete listing, including number of licensed beds, see: Commission on Hospitals and Health Care,"Inventory of Health Services, Connecticut 1976."

As of March 1975 hospitals in Connecticut (excluding governmental facilities) employed 39,440 persons, approximately 3.2% of the state's non-agricultural work force (per conversation with Mr. Vannucini, Division of Research and Information, Connecticut Department of Labor).

Health regulation with a great deal of consumer input was the aim of the authorizing legislation (P.A. 73-117). The fifteen-member commission is appointed primarily by the governor. Composition of the commission is statutorily defined to include: the three State Commissioners of Health, Insurance and Mental Health; eight public members who have no affiliation with the health care industry; and four health care providers, including a practicing registered nurse, and the representatives of the Connecticut Hospital Association, the Connecticut State Medical Society, and the nursing home industry.

Assisting the commissioners are the commission's executive director (appointed by the commission) and the two divisions of CHCC staff.* Both the Division of Health Care Planning (formerly the State's "a" agency under P.L. 89-749) and the Division of Health Care Finances are under administrative control of the State Department of Health. Both divisions functionally report to the executive director of the commission.

Figures I and II display two aspects of the organizational structure of the Commission on Hospitals and Health Care. In Figure I the internal composition of the commission is exhibited. Figure II displays the commission's place in the Connecticut state government structure.

The commission began operations on 1 October 1973, supported by both state general revenues and Federal funds. For fiscal year 1976, the commission' operating budget was approximately $400,000, of which $137,000 was Federal money earmarked for planning. As of fiscal year 1977, approximately two-thirds of the funds to support CHHC's planning activities will come from the state. The remaining third (approximately $40,000) of the planning division's budget will be derived from Federal funds.[19]

Concentration of Regulatory Activities at the State Level

The Commission on Hospitals and Health Care was established as a forum for the combined efforts of consumers, providers and specified

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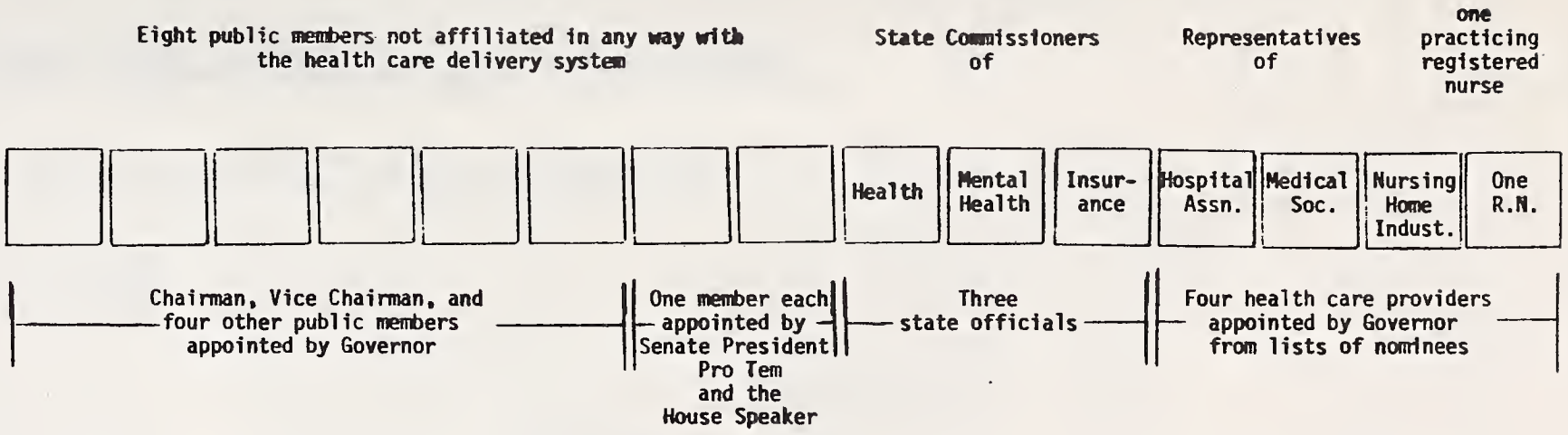
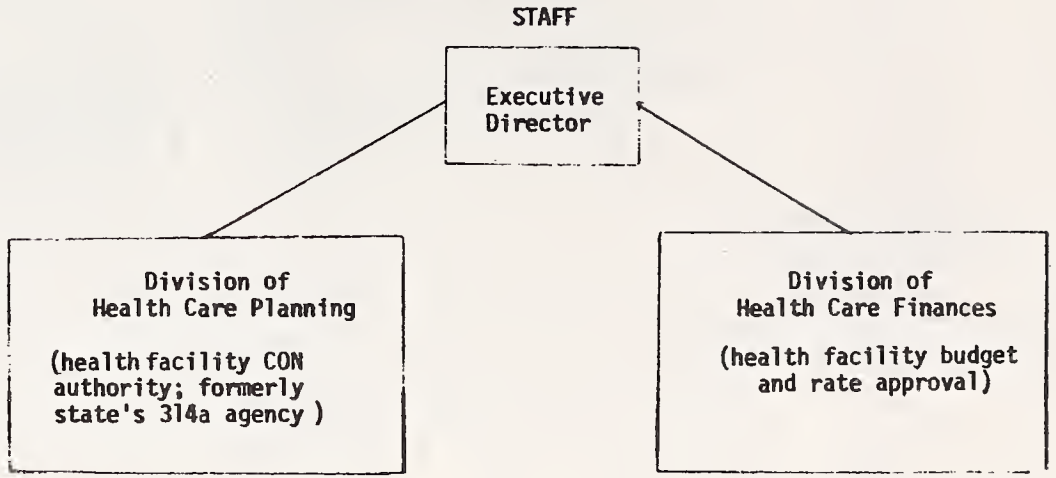
* The executive director is the only member of the CHHC staff who is not an employee of the state's civil service system.

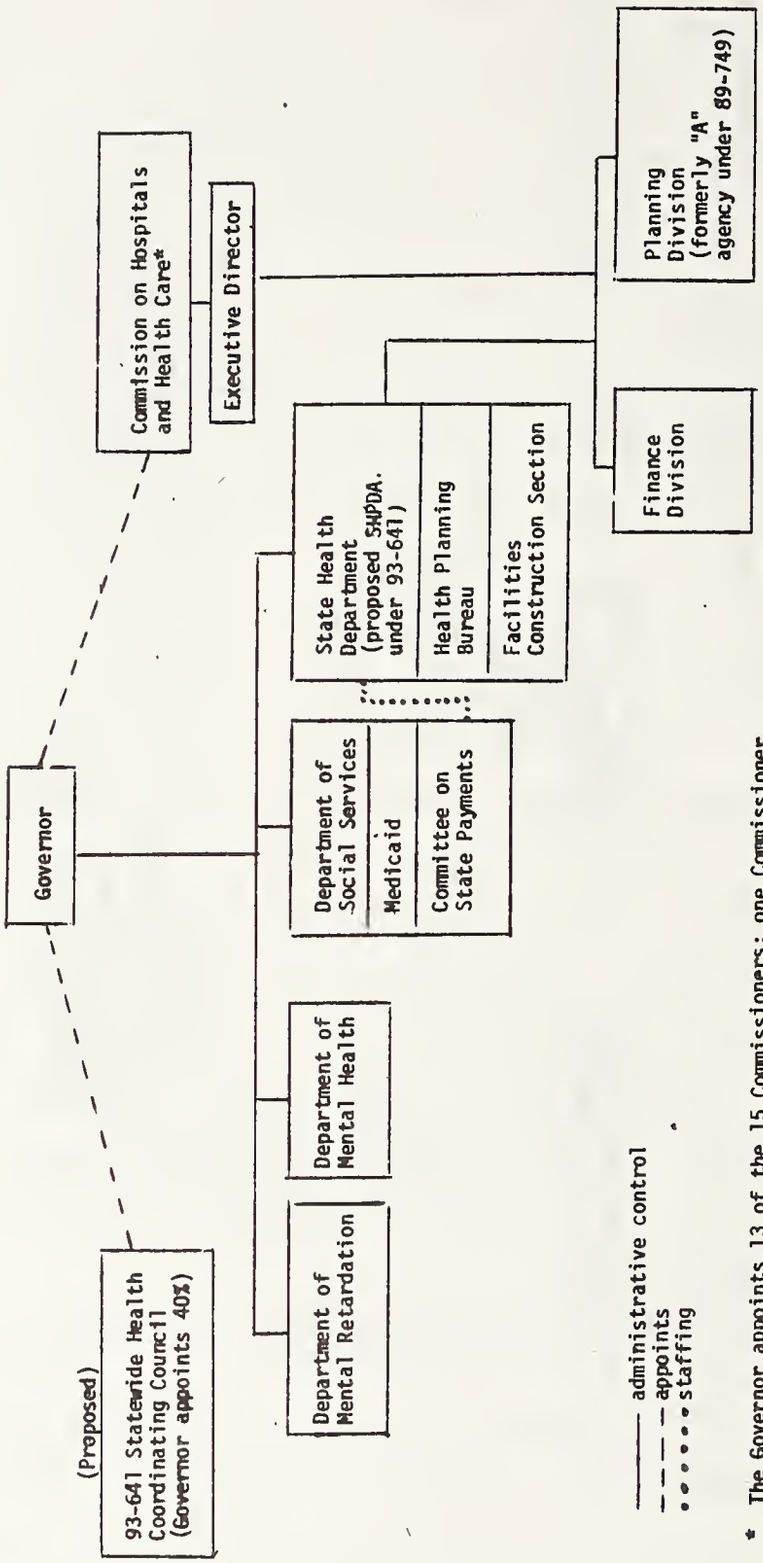
COMMISSIONERS





Organization chart provided by M. William Edwards, CHHC Public Information Officer.

FIGURE II. CHHC'S PLACE IN CONNECTICUT'S GOVERNMENT STRUCTURE



* The Governor appoints 13 of the 15 Commissioners; one Commissioner is appointed by the Senate President Pro Tem; one by the House Speaker.

[Figure adapted from organizational chart appearing in: Council of State Governments, Health Cost Containment: The Connecticut, Maryland, and New Jersey Responses, (Lexington, Kentucky, March 1976). p. 5]

state officials. CHHC is funded by state, rather than local, funds. Together, these characteristics of the commission reflect the tendency in Connecticut to concentrate health regulatory activities at the state level. The commission's involvement with state-level agencies is greater than its participation with local agencies for several reasons:

(1) The fact that the two staff divisions of the commission are under administrative control of the State Department of Health has already been mentioned.

(2) Many of the CHHC staff are veterans of other health-related departments in the state government. For example, prior to the establishment of the commission, the planning division had been located in the state health department, where it had functioned as Connecticut's 314a agency. In addition, the new director of the Health Care Finances Division had previously served for twelve years with the Committee on State Payments.

(3) CHHC and the Committee on State Payments (see page 56) have been affiliated since the commission was first organized. The chairman and vice-chairman of the commission are among the five ex-officio members of the Committee on State Payments (the three others are: The State Comptroller, the Welfare Commissioner, and the Commissioner of Finance and Control). Staff members of the commission's Division of Health Care Finances used to perform cost analyses for the Committee on State Payments, reviewing and analyzing financial data submitted by health providers.

(4) In Connecticut, receipt of certificate of need authorization is prerequisite to licensure of health facilities. An oversight process exists between the commission and several state licensing authorities: in order for a facility to receive a license from the Department of Health, the Department of Mental Health, or the Department of Mental Retardation, it must first obtain CON approval from the commission.

(5) Interaction between the commission and local agencies has been relatively limited. Connecticut has been described by one state-level health planner as a "late bloomer" in terms of 314b agencies' capabilities to review hospital proposals or develop local area plans. That tradition of limited input from the "b" agencies seems to have carried over to the state's five HSAs. In recent months, the HSAs (all formerly "b" agencies) have been preoccupied with hiring staff and some have had little time for project analysis.

The history and general responsibilities of the Commission on Hospitals and Health Care have been outlined. The context of state government predominance in regulatory activities in Connecticut and the nature of CHCC's affiliations with other agencies have been described. It remains to:

(1) elaborate on the commission's powers and duties;

(2) provide a detailed description of the procedures and information used to coordinate the certificate of need and rate review processes at CHHC.

DUTIES AND POWERS OF THE COMMISSION ON HOSPITALS AND HEALTH CARE

Provisions regarding the commission, its membership and its duties and powers appear in Chapter 334A of Connecticut's General Statutes, Section 19-73a through Section 19-73t. Among the commission's legislated responsibilities are several key health regulatory functions:

(1) Budget review (Sec. 19-73o). Annually the commission reviews and approves, denies or modifies the operating and capital expenditure budgets for the next fiscal year of every hospital and any other health care facility

requested by the commission. If the commission denies or modifies a budget (as is usually the case) it must hold a public hearing within 10 days of its decision, and make a final budget recommendation within 15 days of the hearing.*

(2) Review/approval of rate increases.

(Sec. 19-73i(b)) The commission is required to hold public hearings and approve, deny, or modify proposed rate increases for:

a. Any hospital wishing to increase its per diem patient room or aggregate special services charges by more than 6% over a 12-month period, or 10% over a 24-month period.

b. Any nursing home wishing to increase its periodic room rates per patient or aggregate special services per patient by more than 4% over a 12-month period, or 6% over a 24-month period.

(3) Review/approval for capital expenditures.

a. Requests for $100,000 or more (Sec.19-73m): Facilities must submit requests for approval 90 days before initiation of the proposed project. Proposal requires public hearing and commission approval.

b. Requests for expenditures over $25,000 but less than $100,000 (Sec. 19-73n). Facilities must file requests for approval at least 30 days prior to the proposed initiation date of the project. A public hearing is not required unless "a majority of the commission believes the project is not reasonable under the circumstances."

(4) Review/approval of requests for new function or service. (Sec. 19-73 l) Any facility wishing to introduce any additional function or service to its program of health care must request permission from the commission 90 days in advance of the project's proposed starting date. The commission will grant or deny the request within 90 days after evaluating such factors as the "availability of such service or function at other health

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* The statutes require hospitals to submit their budgets to the commission 90 days prior to the proposed adoption date of the budget. All hospitals in Connecticut have a uniform fiscal year, October 1-September 30. Hence, the budget review-and-hearing process represents a very densely packed schedule for the commissioners and staff.

> care facilities or institutions within the area to be served, [and] the need for such service or function within such area."

The commission may promulgate regulations to carry out its duties (e.g., statewide utilization review; formation of a statewide health care program for improving delivery of services; annual reports) (Sec. 19-73r, Sec. 19-73h). Any act or order of the commission is subject to judicial enforcement through the court of common pleas (Sec. 19-73 g).

COORDINATION OF HEALTH PLANNING AND HEALTH CARE FINANCES AT CHHC

Several general characteristics of the Commission on Hospitals and Health Care contribute to an atmosphere of cooperative effort in reviews and easy exchange of information between the health planners and rate setters on the staff. First, the commission's headquarters are in one building (a five-minute walk from the state capitol building), and the offices of the executive director, the Division of Health Planning, and the Division of Health Care Finances are all located in the same suite of offices. Physical proximity enables staff members to engage in frequent informal discussions of hospitals' proposals, and to gain immediate access to each other's files and documents.

Secondly, although the commission has been in operation for just three years, several of the staff members had previously worked together in other agencies (chiefly the state health department) for some time. Not only do staff members exhibit collegial as well as personal ties; they also are familiar with the components of Connecticut's health regulation "system" through their considerable first-hand experience.

Third, the professional staff is small: each division has five

staff members plus a deputy director. Although such a small staff is a disadvantage in terms of the extensive workload, the Commission does not have to contend with the problem of documents or personnel getting "lost in the shuffle" of a huge bureaucracy.

Earlier in this discussion, we noted that, in the past, the activities of the Division of Health Care Finances tended to overshadow the programs of the Division of Health Planning. Within the last year, two significant changes in personnel occurred which should help to correct that imbalance:

(1) A new executive director was appointed after the position remained vacant for fourteen months.

(2) The individual who had been duputy director of finance since the commission was first organized resigned. His replacement, a person who also had been on the finance staff from the beginning, has a much stronger interest meshing her division's activities with the planning division. The planners and the new executive director welcome the idea.

Closer operational (as well as policy) ties between planning and rate setting have been initiated within the commission. Speaking generally about communications between planners and rate setters at CHHC, the commission's deputy director of planning has emphasized that "all proposals are discussed by members of both divisions."[20] Examples of information exchanged and/or substantiated by these divisions are:

(1) what impact proposals for capital expenditures will have on facilities' budgets;

(2) whether or not a hospital's proposal will likely result in increased rates, and if so, when, and in which services;

(3) the facility's history of financial manage-

ment and reputability, as well as the status of other previously approved projects (based in part on interactions between the facility and the commission, as well as on information available through the Health Facilities Construction Section of the State Department of Health);

(4) number of beds reported by a facility (the number of beds a hospital reports in its annual operating budget is the index both divisions use), changes in facilities' bed complements, as well as the ordering of bed complements;

(5) findings or recommendations of the health care task forces regarding the efficacy or community need for proposed equipment or new services (see p. 58).

A referral process between the planning and finance divisions for concurrent review of the four types of proposals hospitals submit to the commission has not been codified.* Several informal procedures practiced on an ongoing basis deserve mention:

(1) The working files and all documents pertaining to hospitals' proposals are open to the entire staff (and the public).

(2) Site visits to facilities often involve joint participation, with members of both divisions accompanying the commissioners. All staff members are not required to perform site visits, however,and planners are usually more more numerous on the site-visit teams.

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* Summarized, the four types of proposals the commission receives for review-and-approval are: 1) proposals for capital expenditures; 2) proposals for new services; 3) requests for rate increases; 4) proposed budgets. (See pages 64 and 65.)

(3) Staff meetings are held to discuss CHHC policy, future plans and strategies, and current activities and problems. However, the frequency and regularity of these meetings tend to be disrupted during the hectic months of the budget review cycle.

In terms of documentation, certain "cross-over" items on CHHC applications or reporting forms facilitate information exchange between planners and ratersetters. For example, consultation between the two divisions is necessary to verify information received from a hospital responding to question #20 on the application for review of health care facility proposals (Form CHHC-1):

20. Will project cost affect facility rates? If yes, indicate rate increase by specific services affected.

If the hospital answers "yes" to question #20, it is necessary for planning division staff to refer to the finance division to ascertain several facts. In theory, a number of related questions should stem from this single item on the application. First, has the hospital also notified the finance division that it is contemplating a rate increase, and if not, why not? Second, is the rate increase indicated in response to question #20 identical to the rate increase requested from the finance division, and if not, why not? Third, how do the data the hospital has submitted to the planning division to support its proposed project compare to the information it has provided to the finance division to justify a rate increase? Fourth, what is the finance division's assessment of the feasibility of both the proposed project and the proposed rate increase? Although the questions above may not be identical to those the CHHC planners ask the finance staff, they approximate the scope of information actually exchanged. [21]

Review of Health Care Facility Proposals

The Division of Health Planning is responsible for reviewing health care facilities' proposals for:

(a) capital expenditures and

(b) new services.

Proposals are received from hospitals, nursing homes and long term care facilities, as well as drug and alcohol detoxification units. Reviews are conducted on a first come, first served basis. Frequently a facility will have consulted with the planning staff numerous times before ever formally submitting its proposal.

A. Hospitals

A hospital follows the same application procedure, whether it is proposing a capital expenditure (greater than $25,000) or a new service. The steps of the review process are:

(1) The hospital submits Application Form CHHC-1 to the Division of Health Planning. In addition to requiring a description of both the proposed project and the "need for project", this 16-page questionnaire includes items pertaining to:

- the target population;
- anticipated costs of the project;
- how the project will be financed;
- whether or not it will affect facility rates;
- the facility's staffing patterns;
- utilization patterns;
- number of beds by accomodation and service;

- the architectural program;

- a summary of capital expenditures.

The hospital is also required to "describe the next step in the master plan."

(2) Staff members at the Division of Health Planning check the application for completeness, and set up tentative site-visit and hearing dates.

(3) The planning division requests the commission to select three commissioners to hear the proposal. The facility is formally notified by registered mail of the hearing date, and the staff posts notice of the hearing in the local newspaper.

(4) The commission performs a site visit in order to obtain clarification of data provided in the proposal, as well as to get a broader understanding of the project's appropriateness in relation to the general locale.

(5) A public hearing, subject to the Administrative Procedures Act, is held on the proposal. "At the hearing, staff has the prime responsibility of cross-examining the sponsor from a professional viewpoint; this usually requires detailed. . .analysis of the proposal and its financial feasibility." [22]

The panel of three commissioners meets at the conclusion of the hearing to consider what to recommend to the full commission regarding the application. Based on instructions from the three commissioners, the staff then prepares the panel report to the commission. If dissatisfied with the panel report, the applicant may appeal the panel decision before the full commission.

B. Long Term Care Facilities

The Division of Health Planning reviews proposals for capital expenditures from nursing homes, rest homes, and homes for the aged; as well as issues certificates of need for these facilities. The application form required for long term care facilities (CHHC-3B) is shorter and less complex than the hospitals' application.* Because of an administrative link with the Health Facilities Construction Section of the state health department, the planning division does not grant site or architectural plan approval.

Rate Review

Health facilities and institutions are required to file with the Commission on Hospitals and Health Care for approvals of any proposed rate increase exceeding specified percentage amounts (see p. 65). Upon receipt of a facility's request for a rate increase, the Division of Health Care Finances evaluates the necessity and feasibility of the proposed increase. In the finance staff's analysis, the facility's budgets, costs, and other financial data are reviewed.

In its second annual report the commission recommended that the portion of the General Statutes pertaining to its rate review powers be amended. Up to now, the commission has not had authority to initiate rate proceedings to reduce a schedule of rates and charges: an application for rate increases and adjustments must be submitted to the commission before rate review proceedings can commence. The commission has recommended that this subsection be added to the General Statutes:

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* Items contained in CHHC-3B include: ownership; licensure; staffing pattern; utilization rate; costs and how the project will be funded. Unlike the hospitals' application, however, no item specifically asks about the anticipated effect of the proposal on the facilities' rates.

"...If the commission finds any rate or charge of a health care facility or institution to be unreasonably discriminatory or more than just, reasonable and adequate to enable such health care facility or institution to provide properly for the public convenience, necessity and welfare, or the service to be inadequate, it may determine and prescribe adequate services to be furnished and just and reasonable rates and charges to be made by such health care facility or institution . For this purpose, the comission may enter such order concerning the provision of services; the establishment of rates and charges; the refunding of amounts collected under a previously approved schedule of rates or charges after the facility or institution receives notice of an investiguation...which the commission finds are in excess of just, reasonable and adequate rates and charges due to changed needs, cost or circumstances; and such further order as the commission deems necessary and appropriate to carry out the purposes of this chapter." [23]

CONCLUDING COMMENTS

The Commission on Hospitals and Health Care provides a vehicle for close coordination between rate review and review of health facilities' proposals for capital expenditures or new services in Connecticut. Mandated to control institutional health care costs, the consumer-dominated commission was organized in October 1973. Four types of proposals fall within the scope of the commission's review-and-approval duties: (1) health facilities proposals for capital expenditures in excess of $25,000 (proposals of $100,000 or more require a public hearing); (2) health facilities' proposals for a new

service or function; (3) health facilities' requests for rate increases over specified percentage amounts; and (4) hospitals' proposed annual budgets. The Division of Health Planning is responsible for review of health facilities' proposals for capital expenditures or new services; the Division of Health Care Finances reviews hospitals' budgets and rate increases.

This discussion has indicated the methods and information utilized to coordinate activities between the commission's planning and finance divisions. Within each division, a specific sequence of review steps is followed and standardized items of information are collected for those proposals for which the division is primarily responsible. However, exchange of ideas and data between divisions is less subject to specified procedures; communication between planners and rate setters at the commission takes place in frequent informal, rather than routinized, discussions. These conversations are supplemented by referral to files and documents on an "as needed" basis.

Structurally and operationally, the Commission on Hospitals and Health Care affords opportunities for close alignment between rate review and review of facilities' proposals. For several reasons, however, those opportunities have not been optimally fulfilled. Factors both internal and external to the commission have compromised the potential it has for a strong program of health cost containment.

Internal adjustments in program emphasis are necessary to allow health planning priorities to be taken into greater account in rate and budget review decisions. The commission's budget review process is beyond the scope of this discussion. In the context of identifying areas of less-than-desirable performance at the commission, however, it is necessary to mention that, each year, the tight 90-day period required for review of hospitals' budgets imposes an unfortunate hiatus on commission activities not strictly related to budget analysis.

In terms of external factors diluting the commission's capabilities, two points can be made. First, the necessity for two separate prospective reimbursement programs (the commission's, and the Blue Cross program) in a small state with only 35 nongovernmental hospitals is questionable. Statewide standardization of hospital rates for all third-party payers would eliminate discrepancies and duplications of effort inherent in Connecticut's current multilayered reimbursement system. (A $236,000 grant recently awarded to the commission by SSA will fund an experimental program to develop a schedule of equalized rates.) Second, until Connecticut's HSAs become fully staffed and operational, it is not yet known whether more active participation by local planning agencies in the commission's decisions can be realized, or what form it might take.

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FOOTNOTES

1. Sarah S. Hirakis, M.P.H., Deputy Director of Planning, Commission on Hospitals and Health Care, personal conversation, 15 September 1976.

2. Per P.A. 73-117.

3. Diane Rowland, Connecting Certificate of Need and Rate Review in Arizona, Harvard Center for Community Health and Medical Care Report Series R-45-12, Boston, July 1976, p. 1.

4. Per P.A. 73-117.

5. Commission on Hospitals and Health Care, First Annual Report to the Governor and General Assembly, 1 January 1975, Hartford, p. 23.

6. Dennis May, "A Report on Prospective Reimbursement in Connecticut," Hospital Progress, September 1975, p. 92.

7. May, "A Report on Prospective Reimbursement in Conn.," p. 94.

8. Council of State Governments, Health Cost Containment: The Connecticut, Maryland and New Jersey Responses, Lexington, Kentucky, March 1976, p. 15.

9. Hirakis, personal conversation, 7 October 1976.

10. Commission on Hospitals and Health Care, Second Annual Report to the Governor and General Assembly, January 1, 1976, Hartford, p. 17.

11. May, "A Report on Prospective Reimbursement in Conn.," p. 94.

12. Hirakis, personal conversation, 7 October 1976.

13. Council of State Governments, Health Cost Containment, p. 7.

14. Council of State Governments, Health Cost Containment, p. 12.

15. Hirakis, personal conversation, 15 September 1976.

16. Commission on Hospitals and Health Care, "Bed Utilization in Connecticut General Hospitals, June 1976," Hartford, p.2.

17. Council of State Governments, Health Cost Containment, p. 1.

18. Commission on Hospitals and Health Care, First Annual Report, p. 1.

19. Hirakis, personal conversation, 7 October 1976.

20. Hirakis, personal conversation, 15 September 1976.

21. Hirakis, personal conversation, 15 September 1976.

22. Commission on Hospitals and Health Care, First Annual Report, p. 10.

23. Commission on Hospitals and Health Care, Second Annual Report, p. 6.